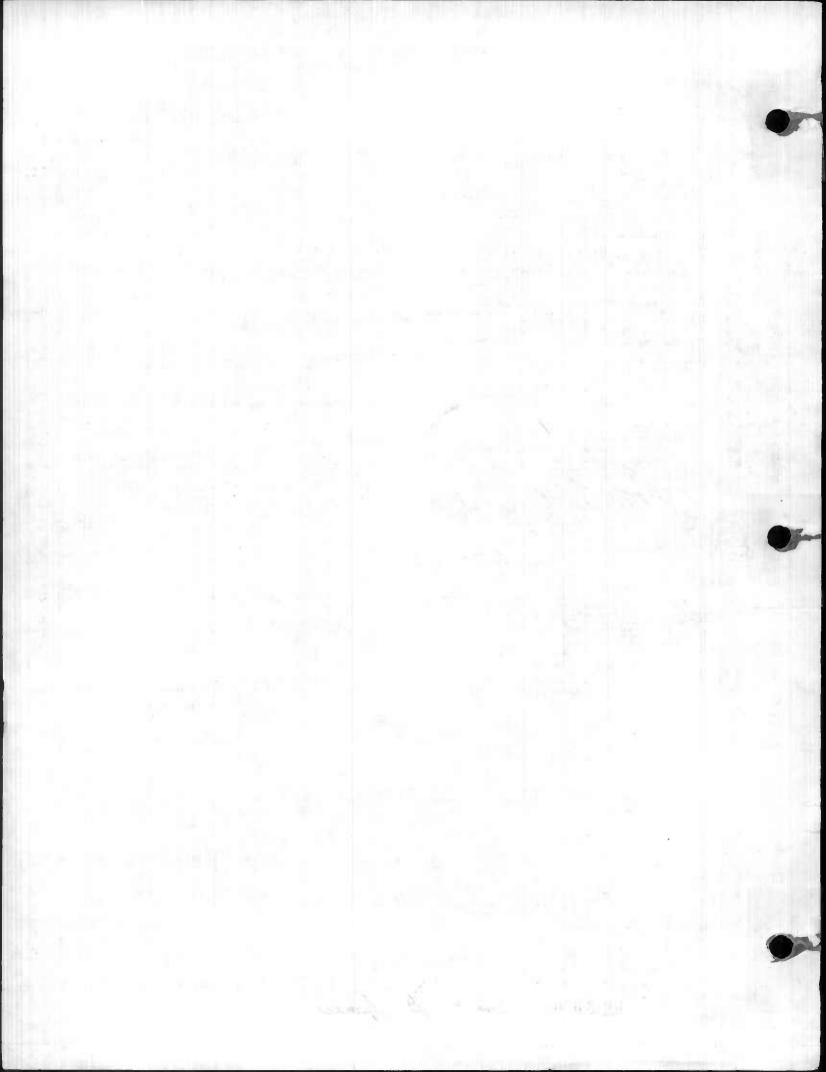
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Dey Month **Physician** Alberta July 25, 1999 McRae 11:43 AM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1113 N. Milton Avenue Baltimore Baltimore City If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Months Days Hours Yes Director 216-34-6629 66 March 14, 1933 North Carolina Usual Residence of Decedent with the Maryland f ahow 10a. State 10c. City, Town or Location 10d. Insida City Limits r than "natural", or forms 23a or 28a-f ahor the Medical Examinar must be notified at MD Baltimore City Director Baltimore Yas 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1113 N. Milton Avenue 21213 United States death v Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. filed within 72 hours after Specify: African 1 Never Married 2 Merried Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Private Sector 10 Secretary permit. Pages 1 and 2 should be filed. Department of Health and Mental Hyg Important: If Itam 27 Is marked other any Injury or other traumatic avant, 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Be William Ingram Della Little 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Bishop LeRoy McRae 1113 N. Milton Avenue, Baltimore, MD aitimore. 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location · City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 7/31/99 4 Donation 5 Other (Specify) Baltimore, MD Loudon Park Cemetery 22. Name and Address of Fecility 21. Signature of Fune Service Lio Loudon Park Funeral Home, 3620 Wilkens Avenue Baltimore, Maryland 21229 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart feliure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner sician and burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial certificata be Physician/Medical Due to (or as a consequence of) attending ( ed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by d 2 No 1 Yes 3 Probably 4 Unknown Records. b bleen si 24b. Were autopsy findings available prior to completion of causa of deeth? 24a. Was an eutopsy performed? Completed certificata has 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of VItal funaral director, 25. Wes case referred to medical examiner? 8 26. Piace of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 17 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27 Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending or Attanding after death. **€2** Accident 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide Mospital 24 hours Funeral Cortifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the ceuse(s) and manner stated. Medical 29e. Certifier pletely (Check only one) To the To the F 29b. Signature and title of certified 29c. License number 29d. Deta signed (Month, Day, Year) address of person who completed cause of death (Item 23a) (Type, Print)

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decadant's Nama (First, Middla, Last) 2. Data of Daath 3. Time of Death Day Month **Physician** July 29, 1999 2:00 PM Patricia Petrie Minty /Medical 4a. Facility Nama (If not institution, giva straat and numbar) 4b. City, Town, or Locetion of Daath 4c. County of Daath Examiner Gilchrist Center Towson Baltimore Hours Min. 8. Date of Birth (Month, Day, Year) FEB 25, 1924 If Undar 1 Yaar 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foreign **Funeral** 1 □ M 2 🛛 F Days Indiana 311-20-8709 Yrs. 75 Director Usual Rasidance of Dacadent 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f ahow 7 is marked other than "natural", or items 23a or 28a-f ahov traumatic event, the Medical Experient must be notified at 1 Yes 2 No Maryland Baltimore White Hall Direct 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 2600 Meredith Road 21161 USA Funeral 12. Was Dacedant Evar in U.S. Armad Forcas? ↑₹□ Yas 2 □ No if Yas, Giva Yaar or Dates: 1943–45 11. Marital Status Was Dacedant of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Raca - Amaricen Indian, Black, White, etc. 1 Never Marriad 2 Married 1 Yas 2 No Spacify: ρ Specify: White 3 Widowad 4 ☐ Divorced Decedent's Usual Occupation (Giva kind of work dona during lifa. DO NOT usa retired) 15 Dacedant's Education 16b. KInd of Business/Industry (Spacify only highast grada complated) during most of working MINTY PATRICIA and Mental Hygiene. Elamantary/Sacondary (0-12) College (1-4or 5+) Homemaker Domestic 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Harry Petrie Rubie Hayhurst 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If itam 27 is any injury or other tra Susan Minty-Riehm/Daughter 2600 Meredith Road White Hall, MD 21161 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 🔀 Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Othar (Spacify) Metro Crematory, Inc. 7/30/99 Baltimore, MD 21. Signature Funeral Sarvice 22. Nama and Address of Facility A. Cremation Society of MD, Inc. Gragorchik 299 Frederick Road Baltimore, MD 21228 Edward 23a. Part1. Entar the diseast of complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest shock, or heart failure. Let only one cause on each line. Intarval Batween Onsat and Death **Physician** pulmonary fibrosis idiopathia Immediate Cause (Final disaasa or conditior rasulting in daath) Years Examiner The law requires that the death certificate be executed Saquentially list conditions, if any, leading to Immadiata ceuse. Entar Undarlying Cause (Disaasa or Injury that init and support of the conditions of the c Dua to (or as a consaguance of) physician at Division of Vital Records, P.O. Box 68760 Physician/Medical that initiated events rasulting in death) Last Dua to (or as a consaquance of): been signed by the should be detached Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 10 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed i certificate has b 1 Yes 2 No 1 ☐ Yas 2 ☐ No Attending Physician: 25. Was cesa rafarred to medical axaminar? 26. Placa of Daath (Check only ona) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Spacify) 1 Yas 25 No 1 Inpatiant 2 ER/Outpatiant 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Natural 2 Accident 5 Panding invastigation death. 1 Yas 2 No i or Attendering of the deat in 24 hours
the Funeral Directory filled in by the 6 Could not be determined 3 ☐ Suicida 28e. Place of Injury - At homa, farm, straet, factory, office building, etc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as statad.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at tha time, data and place, and due to the cause(s) and manner statad. 29a. Certifier To the Hosp within 24 ho To the Fune completely f (Check only one) 29b. Signature agd title of certify 29d. Data signed (Month, Day, Year) Toly29, 1988 e of death (Item 23a) (Type, Print) GAMC 6701 M. Charles St. 31. Data filed (Month, Day, Yaar) 32. Registrar's Signatura State JUL 30 Registrar



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	/Medi		4e. Facility Name (If not institut.	ing dive etreet and o	im hor)		MYERS	Ab Ciby To	our or f	JULY  Location of Deat	20	1999	1925
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an	d be ental	o Be	Shields Curti		fe					e Lovell			
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ā,	F Hee		20e. Method of Disposition	19010,0011	20b. Ple		sition (Neme of netory or other pi		1100	Date	20c. Location		
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o,	requires that the death certificate be executed seen signed by the attending physician end thould be detached for use as the burial-transit	edical Examiner	Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that Initieted events	,	Denut	0000	Vac	Pula	11/	Misego	0.	1	
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~			30. Name and address of person		se of death (Item )	3a) /Tuma 1		1			1/2	-11	1
()	$\alpha$		30. Name end eddress of person Dr. Zahir Yo					ick	May	w1and	20670		

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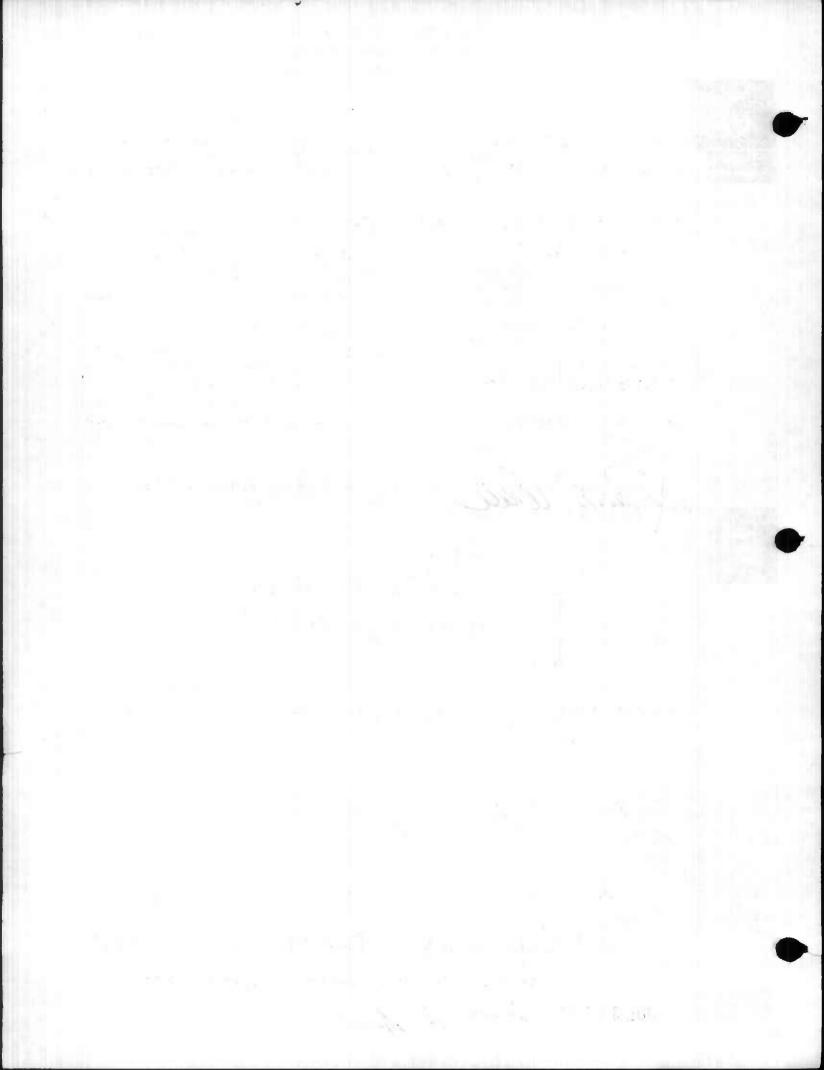
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31. Date tiled (Month, Day, Year)

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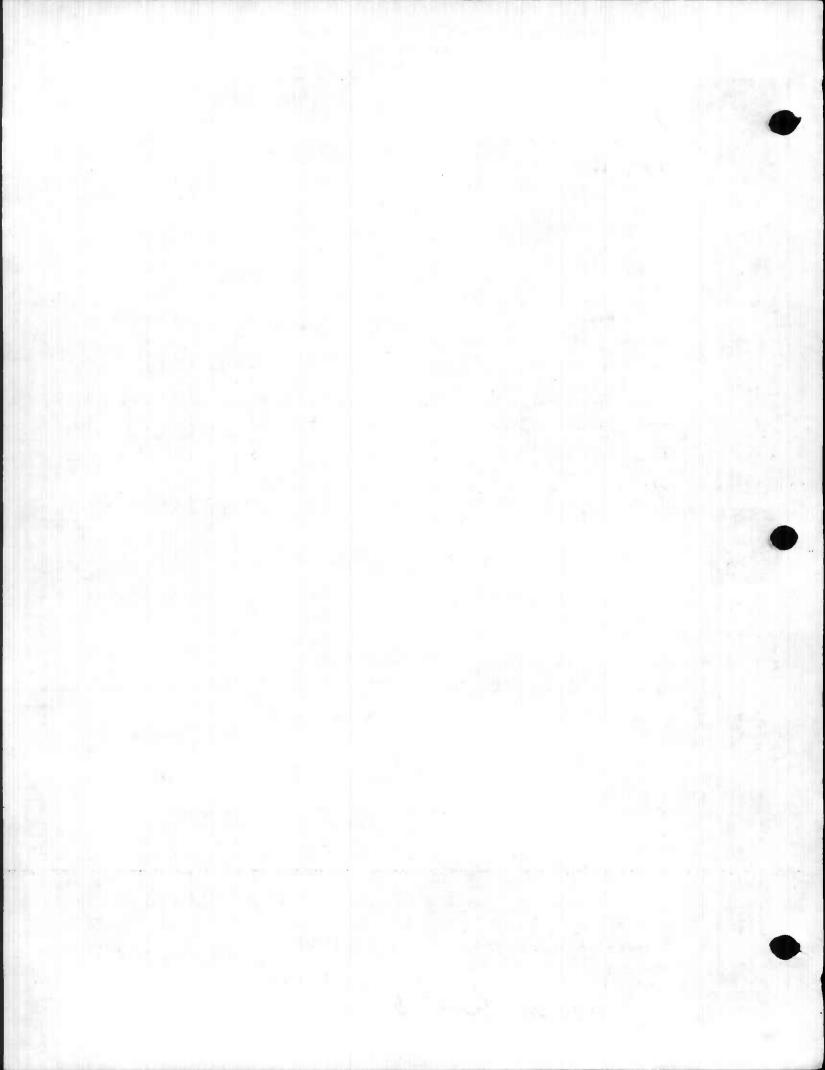
State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** 07 WILLIAM MOORE 25 /Medical 4e Facility Nema (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNIV. OF MARYLAND BALT. BALT. If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Sociel Security Number 8. Sex 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Months Days Hours 4860 6656 1 M 2 F Director 46 25,1953 MARYLAND JULY Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits MARYLAND n/A BALTIMORE 1 Yes 2 □ No Director 28a-f 10f. Zip Code 10e. Street and Number 10a. Citizen of Whet Country? 23s or 601 S. LIGHT STREET 21202 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Herra 12. Was Decedent Evar in U,S. Armed Forces? 14. Bace - American Indian, Black, Whita, atc. 11 Meritel Stetus filed within 72 hours after 1 Nevar Married 2 ☐ Married Yes 2 No Baltimore, Maryland 21215-0020 6 1 Yes 2 No Specify: à 3 Widowed 4 Divorced AFRO-american Year or Detes Completed 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) SOCIAL SECURITY 12TH CLERK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental is marked WILBERT THOMPSON ANNA MOORE 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Nem 27 Is any Injury or other trau ANNA MOORE / MOTHER 3538 PELHAM AVE BALTO, MD. 21213 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Deta 20c. Location - City or Town, Steta Burial 2 Cremation 3 Removel from State ZION CEMETERY july 31, 1999BALTO, MD. 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility CALVIN B. SCRUGGS FUNERAL HOME PRESTON ST. BALTO, 1412 E. 21213 23a. Part1. Entar tha disease, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear feilure. List only one cause on each line. Approximeta Interval Between Onset and Death **Physician** /Medical Immedieta Causa (Final Sepsis disease or condition resulting in death) Examiner Examiner be axecuted Sequantially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequence of): physician s the burial 68760 Physician/Medical Due to (or es e consequenca of): P.O. Box Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? been signed by t ahould be detact 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Records, by 24b. Wera autopsy findings available prior to Completed 24a. Was en autopsy performed? completion of cause of death? 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica Be 25. Was casa referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1. Neturel 5 Panding 1 ☐ Yes 2 ☐ No Investigation 2 Accident 3 Suicide 6 Could not be 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) filled in by 4 | Homicide within 24 hours a
To the Funeral E
completely filled 1 Certifying Physicien: To the best of my knowledge, daeth occurred at the tima, data and place, and dua to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier \$ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 michael a Kolnich 41396 7/25/99 30. Nama and address of person who completed causa of death (Item 23a) (Type, Print) MARYLAND Hospita DE MICHAel Kolnick UNIV. 31. Data filed (Month, Dey, Year) 32. Registrar's Signeture State

DHMH 16 Rev 6/95

Registrar

JUL 30

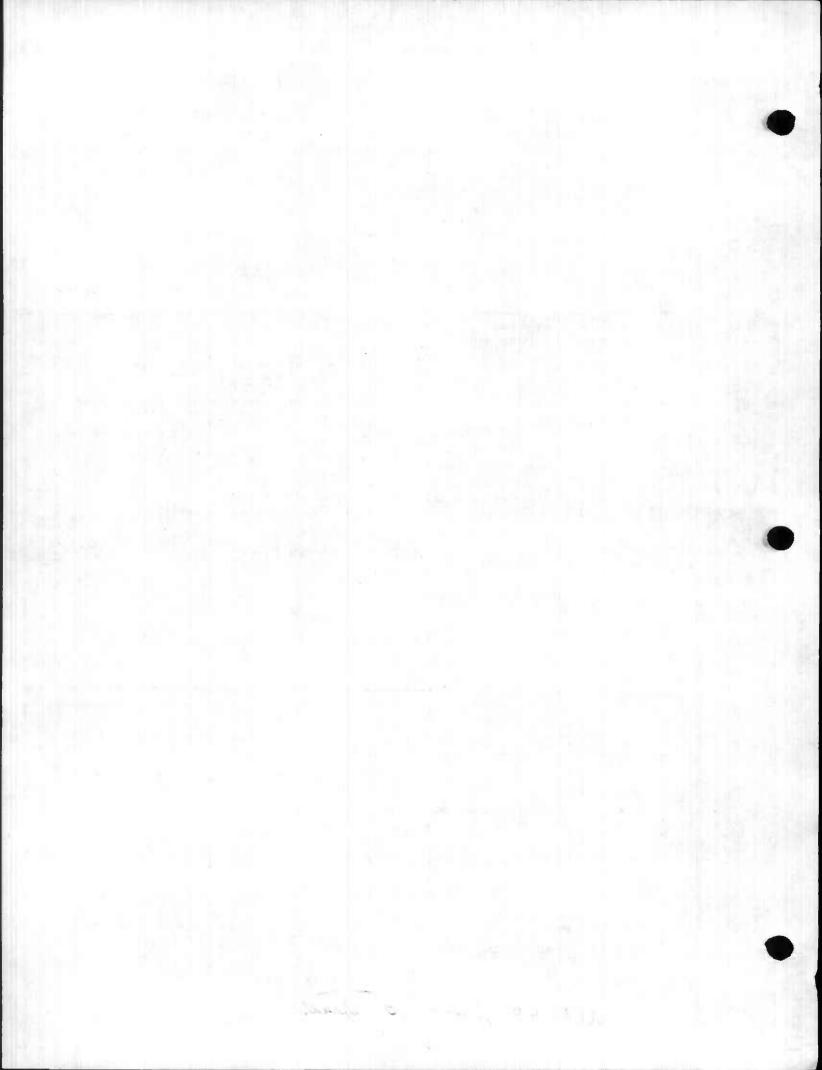


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State of Maryland / Department of Health and Mental Hygiene

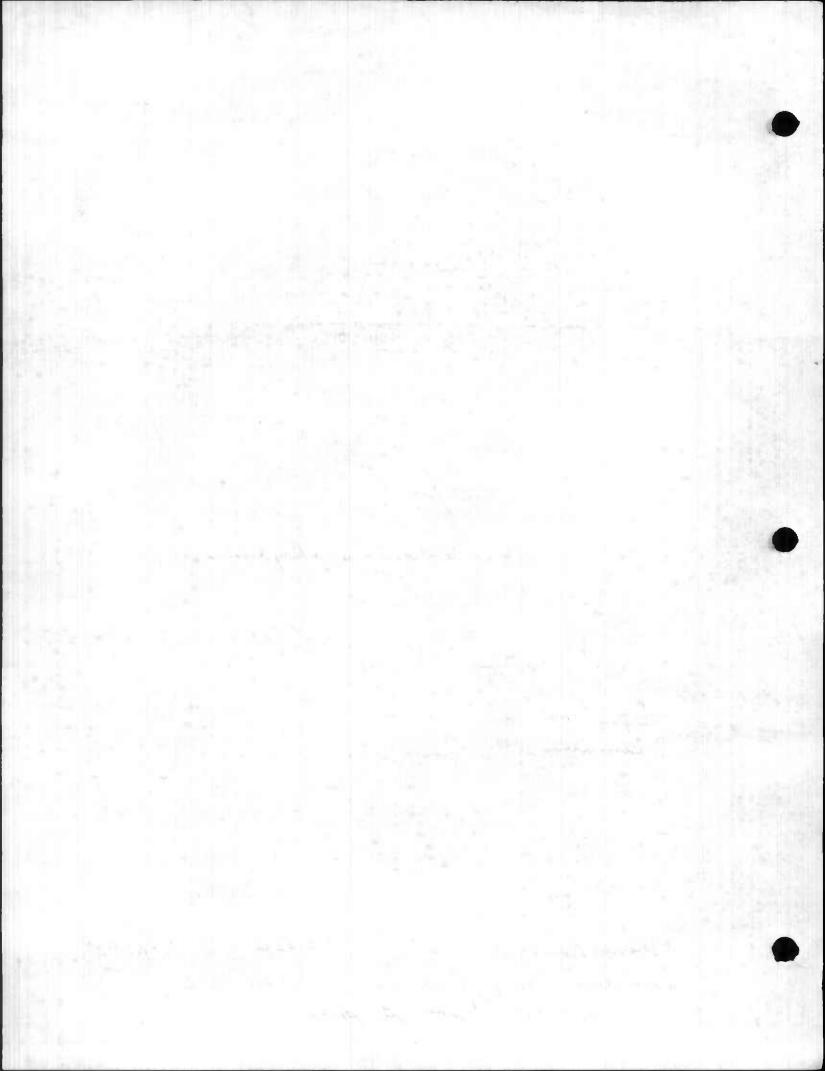
24005 Certificate of Death

		_	1. Decedent's Name (First, Middle, Li	ist)					2. Date of [	_		3. Time of Dea	eth
	Physician	_	Frank A. Manf:	ra, Sr.					Month	7 - 26 - 9	9 Year	9:00an	1
	/Medica Examine		4a Facility Name (If not institution, gi					4b. City, Tov	vn, or Location of De	ath 4c. Cour	nty of Death	)	
	Examine		Hopkins Bayvi	ew				Balti	more	r	ı/a		
	Funeral				(In yrs. las	t birthday)	If Under 1 Yes		Min. 8. Date of E	lirth	9. Birth	place (State or Fo	reign
п	Director		100-16-8367	¹⅓ <sup>M</sup> 2□ F 7	6	Yrs.	Months Day	/s Hours	Min. 8 (Month, 1	22 1001)	NY	intry)	
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	ep .	Funeral Director	11, Merital Stetus	12. Was Decedent E Armed Forces?		13. V	Vas Decedent of Yes, specify Co	f Hispanic Orig uban, Mexican,	in? (Specify Yes or I Puerto Rican, etc.)	lo- 14. R	lace - Ameri lack, White	ican Indian, , etc.	
20	after of the same	Dy T	1 Never Merried 2 Married	1 ☐ Yes 2 ☐ No	° WW2		□Yes 2☐X			Spec	city:	WHITE	
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Maryland	d Me	2	19a. Informant's Neme/Reletionship			19h Mailin	o Address /Stre	net and Numbe	r or Rural Route Nun	her City or Toy	m State 7	in Code)	
Z	trau		Mrs. Bernice				_		Balto.,				
re,	Hea lem other	1	20e. Method of Disposition		20b. Plac	e of Dispos	sition (Name of		Date	20c. Locatio		Town, State	
9	age and of H. H. H. H.		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci				natory or other p nislau		7-29-99	Balto	) N	/ID	
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at posses.	-	21. Signature of Funeral Service Lice		00.								
Ö	Depa Impo eny i			K					uneral I		220	MD 212	22
		+	23a. Part1. Enter the disease, or con shock, or heart failure. List only	ndications that caused	the death.				Avenue I		ne,	Approximate	
1	Physician		shock, or heart failure. List only	one cause on each line	θ.						1	Onset and Deat	
J	/Medical		Immediate Ceuse (Finel	IA. S	10.	1.5	1 in	Larci	Lr.		i	hours	
п	Examiner		disease or condition resulting in death)	a	oceur	0119	unnon of):	1-11-61	10 n		I I		
					200 10 (01 0	3 4 90/1304	301103 017.						
	es that the death certificate be executed goed by the attending physician and be detached for use as the burist-transit by Dhysician and the burist-transit by Dhysician and the burist-transit by Dhysician and the burist-	an/medical cxaminer	Sequentially list conditions,	b	Due to (or a	s a consequ	uence of):				1		
ó	an ar ar infalt	Ŭ	if any, leeding to immediate cause. Enter Underlying								i		
Box 68760,	nte br	20	Cause (Diseese or Injury that initiated events resulting in death) Last	C	ue to (or e	s e consequ	uence of):				1		
9	ing pl	M											
30	th ce the			d							1		
_	s eth	Fnysic	Part II. Other algorificant conditions	contributing to death but	t not resulti	ng In the un	derlying cause	given in Pert I.	23b. Di	d tobecco use	contribute	to the cause of d	eth?
0.	requires that the de een signed by the s hould be deteched I								1(	Yes 2 N	3 3 Pm	obably 4 Uni	nown
Records,	signe d be of	Completed by									1 24b b	Vere autopsy findi	200
0	been si	200							248. W	es an autopsy rformed?		vailable prior to completion of caus	
Sec	The law		_						_		0	of death?	
	cate . Pag.	3							10	Yes 2 KNo	1.	Yes 2 No	
Viita	ysicien: The last certificate hadirector, page		25. Was case referred to medical axaminer?	Hospital:					of Death (Check on)	y one)			
	Physicien: this certific ral director,		1 ☐ Yes 2⊠ No 27. Manner of Death	1 LI Inpatien		VOutpatient	3LI DOA		rsing Home 5 Re	sidence 6 🗆 e how injury oc		city)	
C C	After funer	5 '	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year)	Bb. Time of Injury	28c. In V	Vork? ☐ Yes 2 ☐ t		e now anjuly oca	.urreu		
S	Attending in death.	2	2 Accident investigation 3 Suicide 6 Could not to	De Diese of faire	nr - At horn	o form etre				(Street and Nu	mher or Ru	ral Route Number,	
Division of	tal or Attending P rs after death. al Director: After t led in by the funera		4 Homicide determined	building, etc.	(Specify)	e, iaiii, stre	et, lactory, onic			own, State)	11001 01 110		
	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral mandless of partitions of the funeral mandless of partitions of the funeral mandless of the funeral mandless of the funeral flags.		29a. Certifier 15 Certifying Pl	nysician: To the best of	my knowle	edge, death	occurred at the	time, date and	place, and due to #	e cause(s) and	menner as	stated.	
	To the Hospital within 24 hours To the Funeral completely filled	2		miner: On the basis of e and manner state	examinetion								
	within To the		29b. Signature and title of certifier	1			29c. Lice	ense number		29d. Date sig	ged (Month	n, Day, Year)	
			1 South 1/4	bes .	41		14	2237	2	7/29/	99		
		1	30. Name and address of person who	completed cause of de	ath (Jtem 2	3a) (Type, F	Print)	A			-		
			2112 Dunda/1	t tue	1Sq	Him	are i	10 3	1555				
	State		31. Date filed (Month, Day, Year)	32. Registrar	r's Signatur	0 /	1	1	7				
	Registrar	r	1111 3 0	1999	mener	Ø	. 100	ucs					



### Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

	Certificate of Death		Heg. No.	3 24006
Physician /Medical	1. Decedent's Nama (First, Middle, Last)  SOPHIA S. MAZUREK	2. Date of D Month JULY	25, 19	Year 999
Examiner uneral	FUTURE CARE CANTON HARBOR BAI  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under	LTIMORE or 24 Hrs. 8. Date of B	N/A	
ctor	212-09-4983 1 M 2 F 85 Yrs. Months Days Hours	Min. (Month, t	2/12	MARYLAND
ō	10a. Stata         10b. County         10c. City, Town or Location           MD         N/A         BALTIMORE			10d. Inside City Limits 1X Yes 2 □ No
DILECT	10e. Street and Number 10f. Zip Code		10g. Citizen of W	
by runeral Director	632 S. POTOMAC STREET  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married   12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 1 No Specify  1 Yes 2 1 No Specify	Origin? (Specify Yes or It an, Puerto Rican, etc.)	Black	A Amarican Indian, s, White, etc.
	3 jarWidowed 4 □ Divorced Year or Dates:  15. Decedent's Education (Specify only highest grada completed)  16a. Decedent's Usual Occupation (Give kind of work done during mo iffe. DO NOT use retired)		Specify:	WHITE siness/Industry
	College (1-4or 5+)  6  0  HOMEMAKER  17. Father's Nama (First, Middle, Last)  18. Moth	her's Name (First, Midd		»)
	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number)		nber, City or Town, 5	
	MISS MARLENE MAZUREK  20a. Method of Disposition  1/28 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cermetery, crematory or other place)  ST. STANISLAUS CEMB	Date	20c. Location - (	City or Town, State
DOG.	21. Signature of Funaral Sarvice Licensee  22. Name and Address of Facil KAC ZOROWSKI  23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such a shock, or heart failure. Out only one cause on each line.	ility I FUNERAL LK AVE. B	HOME P.	A. E. MD. 21222
n al er	Immediata Causa (Final disaase or condition resulting in death)  a. Arterusclevotic Cormony arterioristing in death)  Due to (or as a consequence of):			Interval Batween Onset and Death
dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.			
an/Medica	that initiated events rasulting in death) Last  Due to (or as a consequence of):  d			
Physician/Me	Part It. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part		id tobacco use con	tribute to the cause of death?  3 Probably 424 thinknown
Completed by P	Dementia	24a. W	as an autopsy rformed?	24b. Were autopsy findings available prior to completion of cause
1		10	Yas 20No	ot death? 1 ☐ Yas 2 ☐ No
o Be	examiner? Hospital: Other	ce of Death (Check only		r (Specify)
Certification: T	27. Manner of Death  1 DNatural 5 Pending investigation  3 Suicide 4 Homicide 6 Could not be determined 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work?  28b. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)	28d. Describ	e how injury occurre	
edical Ce	29a. Certifiar  (Check only one)  2 Medical Examiner: On the basis of my knowledge, death occurred at the time, date a construction of the constru			
Oliver	one) and manner stated.	,	29d. Date signed	(Month Day Year)
Med	29b. Signature and title of certifier  Movem Konselecte us  29c. License number  D 210		7-2	7-99
Medical Certifica		22		



D 99-4418-51	O Ple	ase Type or						_		ble.	
ANDRE MOORE		State o	f Maryland				lealth an Death	d Mental Hy	ygiene Reg. No.	3 21	007
MOORE	1. Decedent's Name (First, Mid	dle, Last)				-		2. Dete of D			3. Tima of Death
Physician	Andre Lavell	e Moore						Month JULY	Day 26 10	Yeer	A. AED M
/Medica	An English Manne (Manne Insales)		mhari				Ih City Town	or Location of Dea	26, 19 th 4c. Count		4:45P.M.
Examine				mm							
	JOHNS HOPKINS  5. Social Security Number	6. Sex			If Under	1 Vaar	BALT IN		No		(0)
Funeral		6. Sex 1□XM 2□ F	7. Age (In yrs. last	Yrs.	Months	Deys		Vin. (Month, D	lev. Year)	Countr	ce (Stete or Foreign
Director	216-94-0576 Usuel Residence of Decedent		21	.,,,,				Jan.	13, 1978	Maryl	and
2	10a. State 10b. Coun	tv	10c. City, To	own or Lo	cation					100	I. Inside City Limits
tarytar strone st.at		•									V Yes 2 No
the Maryland 28e-f show soffilied at	Maryland No	ne	Ва	ltimo							
ult with the Ma 23e or 28e-f i unt be notified		ield Ave.			10f. Zip	Code 212	213		10g. Citizen of U	What Country SA	y?
21215-0020  4 within 72 hours after death with the Maryla piers, rethan 'natures', or terms 28 or 28e-f shouth Madical Examiner must be notified at completed by Engage 10 process.	11. Meritel Stefus  1. Never Married 2 Me  3 Widowed 4 Divorce	Armed Fo	2 ⊡*No ⁄e	If	Vas Deced Yes, spec	ify Cuba	ispanic Origin nn, Mexicen, P Specify:	? (Specify Yes or N uerto Ricen, etc.)		ce - American ck, White, et y: Blac	c.
9 2 5		enf's Educetion	10	6a. Deced	lenf's Usua	I Occup	efion		16b. Kind of B	usiness/Indu	stry
od within 72 ho ygiene. wer than "natural, the Medical.	(Specify only high	est grade completed)		(Give i	kind of wor	rk done	during most of	working			
2121 within lane. the Men 'y	Elementary/Secondery (0-12)	College (1	-4or 5+)	Cabin	net M	aker			Unkno	wn	
	17. Father's Name (First, Middle	e, Last)					18. Mother's	Name (First, Middl	e, Maiden Sumer	ne)	
Maryland  42 should be file in and Mental Hy in marked othe traumatic event	5 D							ce Moore		,	
aryla should nd Men marks amarks	-			Oh Mailin	- 4	/Can na				Ctata 7in C	le de l
Man 12 a	19a. Informent's Neme/Relation							r Rural Route Num		A	
0.294.6	Eunice Johnson	n/Motner						ve. Balti	1		
Pages Percent of Mart: It is Mry or o	20a. Method of Disposition  1 Burial 2 Cremation 4 Donetion 5 Other (			etery, crem		ther plea	<b>&gt;e)</b>	7-31-99	20c. Location Woodla		
Ball permit Depart Import any inj ance	2) Signature of Funeral Service	o Licohode	-	Tl	he De	rric		ones Fune			land 2121
Physician	23a. Part1. Enter the disease, shock, or heart feilure. Lis	or complications that c st only one cause on e	eused the deeth. Dech line.								Approximate Interval Between Onset end Death
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	· Mu	(tiple G	unst	not o	Wou	nds			1	
nsit ned			D09 to (0) 95	a conseq	dence or).					1	
D, exect in and fish-tra	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	<b>5</b> b.	Due to (or as	a conseq	uence of):						- 11
. Box 68760, death certificate be executed e attending physician and id for use as the burial-transi	Cause (Disease or Injury that initiated events resulting In death) Last	d	Due to (or es	e consequ	uence of):						
D after d for d for d	Part II. Other algorificant condit	Home contribution to de	anth fruit ant specifies	a la tha un	adach sin a a		on in Doct I	22h Di	d tahaana waa aa	mtelburte to t	he cause of death?
P.O.		none contributing to de	Matri Dut Hot 1650(III)	g in the or	idenying o	ausa giv	en in Fait i.		Yee ZONo		bly 4 Unknow
requirements									s an autopsy formed?	evail	e autopsy findings able prior to plefion of cause eath?
The law ate has page 2								1,02	Cxes 2□No		Pes 2□ No

Division of Vital R Medical Certification: To Be Co To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this

25. Wes case referred to medical exeminer? 1 Yes 2 □ No 27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier (Check only one)

Homicide

Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Othar (Specify) 28b. Time of Injury 28c. Injury et Work? 28a. Dete of Injury (Month, Dey Year)

7/26/99 1555 M 10
28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

1 Yes 2 No

ect shot 281. Location (Street end Number or Rural Route Number, City or Town, State) 3232 Shester Field Baltomere Cety, And Chester field Are

determined building, etc. (Specify) building, 29c. License number

26. Place of Deeth (Check only one)

O.C.M.E.

29d. Date signed (Month, Day, Year) JULY 27,1999

5

d ceuse of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year) JUL 3 0 1999

5 Pending investigation

6 Could not be determined

32. Registrer's Signeture

DHMH 16 Ray 6/95

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Data of Death 1. Decedent's Nama (First, Middla, Last) Day Month Year **Physician** NORRIS MARGARET July 29 /Medical 1999 10:40 AM 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Future Care of the Chesapeake Arnold Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) **Funeral** Months Days Hours 1 M XXF 219 22 3211 Yrs 90 Director Sept 27, 1908 Maryland Usual Rasidence of Decedant 10e. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Director MD Anne Arundel Arnold or 28s-f 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 238 305 College Parkway 21012 Funeral 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, 11. Marital Status Black, Whita, atc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int. If Item 27 is merked other than "natural", or fra 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Specify: ρ 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Hygiene. Elementary/Secondary (0-12) Collega (1-4or 5+) Office Clerk Baltimore City Govt. 10 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nema (First, Middle, Maidan Surnama) Be Cora Howard M. Ziegler Miller 2 19a. Intormant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) Department of Health a Important: If Nem 27 is any injury or other trau Elmer Norris / Son 8527 Creek Rd. Pasadena, MD 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 N Burial 2 ☐ Cremetion 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) 8/2/99 Baltimore, MD Loudon Park Cemetery 21. Signatura of Funaral Sarvice Licensee 22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximete Interval Batween Onset and Death **Physician** Immediata Causa (Finel diseasa or condition rasulting in death) /Medical Cardinvasor Several years Examiner Examiner The law requires that the death certificate be axecuted Sequentially list conditions, if any, laading to Immadiata causa. Enter Underlying Cause (Disease or injury that initiated events rasulting In daath) Last Dua to (or as a consequence of): Box 68760, physician Physician/Medical the Dua to (or as a consequenca of) USA AS P.0. Part II. Other algorificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Onknown sate has been signed by page 2 should be detac Division of Vital Records, Be Completed by 24b. Wara autopsy findings available prior to complation of causa of death? 24e. Was an eutopsy performed? 1 Tyes 1 Yes 2 No certificate Attending Physician: funeral director, 25. Was casa rafarred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) Certification: To 1 Yas 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Data of tnjury (Month, Day Year) 27. Manner of Death 28d. Dascribe how injury occurred 28b. Tima of 28c. tnjury at Work? Atter 1 Natural 2 Accidant 5 Pending 1 ☐ Yas 2 ☐ No death. invastigation or Attend after death Director: / the 6 ☐ Could not be datamined 3 Sulcida 28a. Place of tnjury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) filled in by 4 Homicide Hospital 24 hours a Funeral E Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, end dua to the causa(s) and mannar as stated.

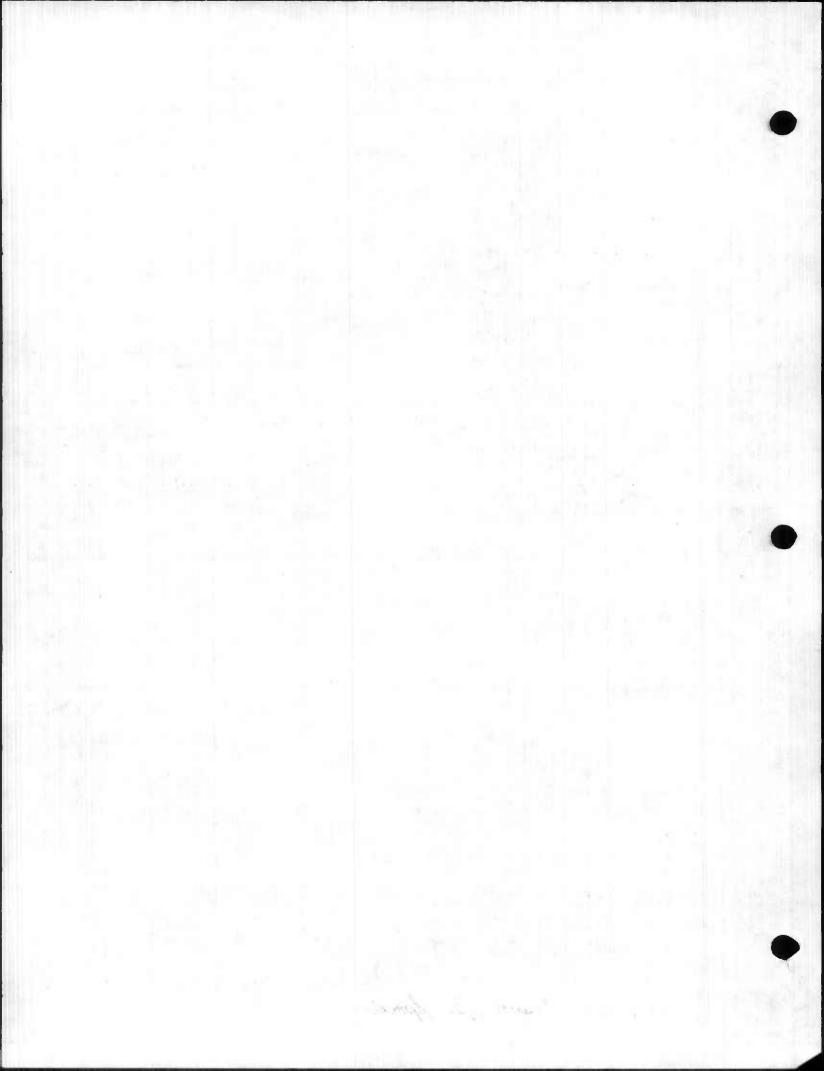
Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and mannar stated. Medical 29a. Certifier (Check only one) To the I within 2 29b. Signatura and titla of certifie 29c. Licensa number 29d. Data signed (Month, Day, Year) Nama and address of person who completed causa of death (Item 23a) (Type, Print) KOBERT EDEN 600 RIDGELY AVE, ANNAPOLIS, MD Scott M.D. 31. Data tilad (Month, Day, Year) 32. Registrar's Signatura

DHMH 16 Rev 6/95

State

Registrar

JUL 3 0 1999

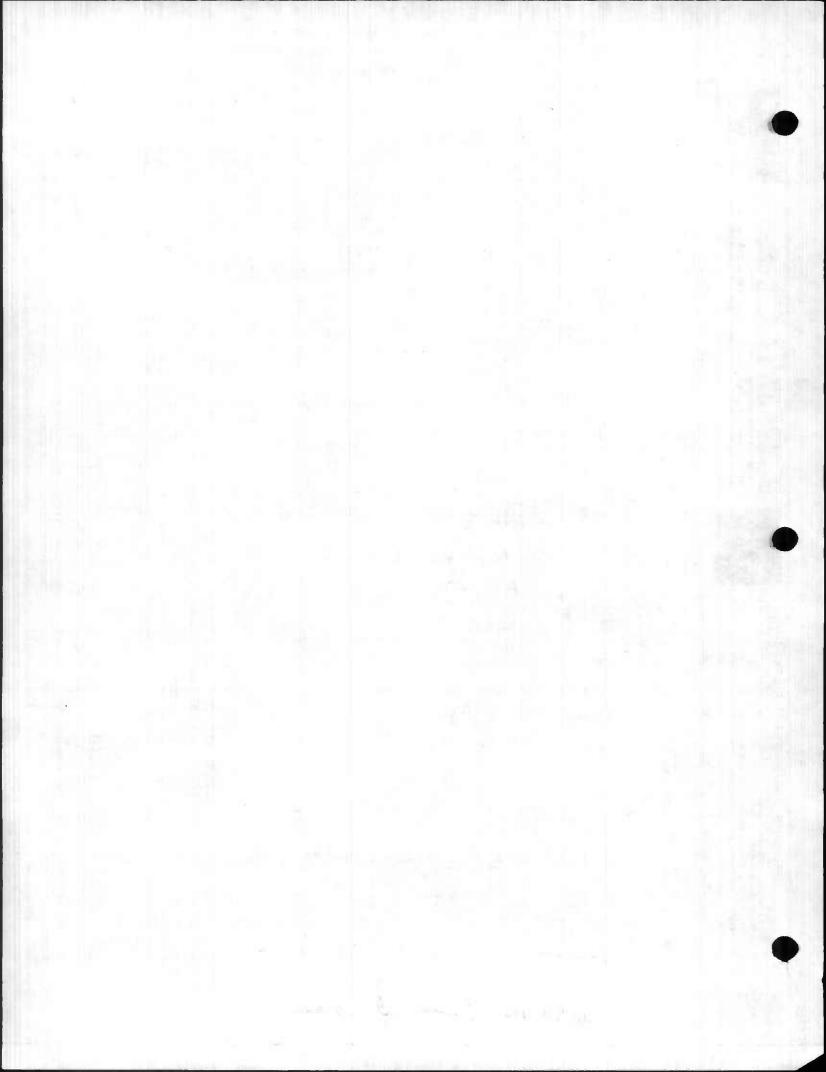


#### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 24009

				Cer	tificate of	Death		Reg. No.		C 7002
		1. Decedent's Name (First, Middle, Last	)				2. Date of D		Vees	3. Time of Deeth
Physic /Med		Amelia Nowakows	ki				7-23	-99 Day	Year	2:30AM
Exami		4a Facility Name (If not institution, give Canton Harbor N	street and number)			4b. City, Town	n, or Location of Dea	th 4c. Coun N/A	ty of Death	
Funeral Director		5. Social Security Number 6. Se		ast birthday) Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of 8	irth	9. Birth Cou	place (State or Foreign ntry)
	-11	Usual Residence of Decedent							1_111	
a Marylan	ctor	MD N/A		Town or Local						10d. Inside City Limits 11 Yes 2 □ No
h with th	al Director	10e. Street and Number 1300 S. Ellwood	Avenue		10f. Zip Code 21224			10g. Citizen of USA	What Cou	intry?
within 72 hours after death with the Maryland ens. then "netural", or items 23s or 28s-f show he Madical Exercise must be notified	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U,S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates;	11	Vas Decedent of Yes, specify Cul	ben, Mexican, F	n? (Specify Yes or Neuerto Rican, etc.)	Bio	ice - Ameri ack, White	
d within 72 hours at glons. rr than "natural", or	Completed	15. Decedent's Edu (Specify only highest grad	cation	(Give I	ent's Usual Occu kind of work done OO NOT use retin	during most o	f working	16b. Kind of I		
A C C	dE	Elementary/Secondary (0-12)	Cotlege (1-4or 5+)				CO	Balti	more	City
D D	Be Co	17. Fether's Name (First, Middle, Last)		Scho	ol Mair	T	Name (First, Middl			Cley
should nd Mer merke	P	Martin Wojtowic  19a. Informant's Name/Relationship (7)	**				or Rural Route Num			
Pate P		Mr. Richard Now			0 Mt. I	Albert	Road E	T		
0 = 0		1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	Removal from State	stan	islaus		7-27-9			
permit. Pa Departmen Important: any injury		21. Signature of Funeral Service Licens	on and i	Ka 1 2	Name and Addr CZOYOW: 01 Dune	ess of Facility Ski Fu dalk A	neral venue B	Home alto.,	MD :	21222
. Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. Listonly o	dutions that caused the death ne cause on each line.	. Do not ente	er the mode of dy	ing, such as ca	rdiac or respiratory	arrest,		Approximate Interval Between Onset and Death
/Medical Examiner		Immediata Cause (Finat disease or condition resulting in death)	Due to (or	20	Mont	س>				
2 =	Jiner		AJUVD AJUVD	es a conseq	uence ot):					YRS
icate be asscuted physician and s the burlet-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequ	uence of):					,
certificate be executed iding physician and sea as the buriel-transit	Medical	that initiated events resulting in death) Last	Due to (or	as a consequ	uence of):					
deeth d for u	Physician/	Part II. Other significant conditions con	atributing to death but not resul	lting in the ur	nderiving cause o	iven in Part I	23h Di	i tobacco usa c	ontribute	to the cause of death
that the de ed by the deteched					donying oddoo g	or arrange.				obably 4 Unknow
ha law requires that tha a has been signed by th aga 2 should be detache	Completed by	Pytic	win , Ans	JMn				is an autopsy formed?	a	Vere autopsy tindings vailable prior to ompletion of cause I death?
두 설립	S						10	Yes 200	1	☐Yes 2☐ No
delan: The cartificata rector, pag	Be	25. Was case referred to medical axaminer?				26. Place of	Deeth (Check only	one)		
the state	on: To	1 Yes No  27. Manner of Death  ORatural 5 Pending	1	ER/Outpatient 28b. Time of Injury	28c. tnje		ing Home 5 ☐ Re 28d. Describe	sidenca 6 🗆 O		ify)
i or Attanding i after death. Director: After d in by the fune.	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, stre		]Yes 2□No	28f. Location	(Street and Num own, Stete)	nber or Ru	ral Roule Number,
To the Hospital or Atta within 24 hours after da To the Funeral Directo completely filled in by the	edicai Ce		sician: To the best of my knowner: On the besis of examination							
ithin of the complete	Me	29b. Signature and title of certifier	and manner stated.		29c. Licen	se number		29d. Date sign	ed (Month	Day, Year)
8 4 8 4		• //			12	2477	6	7.2	688	
	ĺ	30. Name and address of person who or STMON V. SC	empleted cause of death (Item	23a) (Type, F		2862	NURS	was th	mc	
Sta	ate	31. Date filed (Month, Day, Year)	32. Registraris Signati	ure	4 1		. 4	~~	4 1-	
Regist		iii 2 f	1000 h :	w ,	O. 10	acks				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \ Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Death Barbara Virginia Phillips 30, 1999 July 2:42 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Gilchrist Center Towson Baltimore H Under 24 Hrs. 8. Date of Birth Mar 10, 1950 5. Social Security Number If Under 1 Year 7. Age (In yrs. lest birthday) 9. Birthplace (Stete or Foreign 1□ M 2X F Days Maryland 216-52-4321 49 Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locetion 10d. Inside City Limits 1X Yes 2 □ No Maryland N/A Baltimore 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? 2805 Shirey Avenue 21214 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indian, Black, White, etc. Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Elementary/Secondery (0-12) College (1-4or 5+) Computer Programmer Law Firm 17. Fether's Name (First Middle Lest) 18. Mother's Name (First, Middle, Meiden Sumeme) Joseph Phillips Helen Hovermale 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Robert S. Phillips/Brother 10053 Hughes Street Conifer, CO 80433 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 1 ☐ Burial 2 M Cremation 3 ☐ Removal from Stete 4 Donation 5 Other (Specify)

21. Signeture of Funeral Service Licensee Metro Crematory, Inc. 7/30/99 Baltimore, MD 22. Name end Address of Facility Cremation Society of MD, Inc. Edward A 299 Frederick Road Gregorchik Baltimore, MD 21228 implications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiratory arrest ly one cause on each line. Approximate Interval Between Onset end Death tmmediete Ceuse (Finel CAncer 6 months disease or condition resulting in deeth) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last Due to (or as a consequence of) Due to (or as e consequenca of): Pert it. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert it. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evellable prior to 24a. Was en eutopsy completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Mother (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/OutpatienI 3 ☐ DOA 1 Yes 2 No 27. Manner of Death 28b. Time of 28c. Injury al Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident

certificete be executed Box 68760. the P.O. Records, Vital of al or Attanding P s after death. I Director: After t d in by the funera Division

Examin Physician/Medical g Completed Be 10

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

25a-f show

natural, or itsms 23a

Important: If Item 27 is

Physician /Medical

Examiner

must be

the Medical Examiner

Directo

by

Completed

Registrar

DHMH 16 Rev 6/95

To the Hospital within 24 hours a To the Funeral C Hospital

completely

State

296. Signature with title of cartifier

6 Could not be determined

MO

28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end placa, and due to the ceuse(s) and manner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) end manner stated.

29d. Date signed (Month, Dey, Year) July 30, 1999

28f. Location (Street end Number or Rural Route Number, City or Town, State)

30. Name and address of person who completes cause of deeth men 23a) (Type, Print)

GBMC 0 6701

32. Registrar's Signature JUL 3 0 1999

N. Charles St. Balto. Md

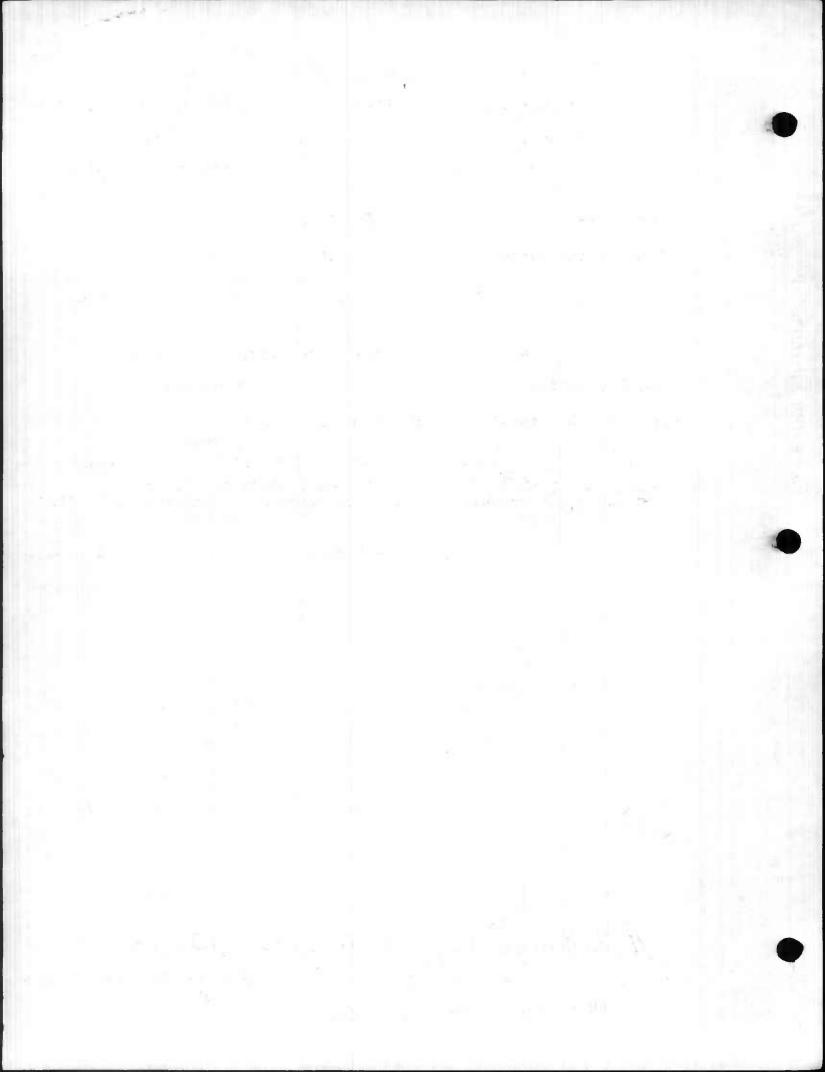
edical

3 Suicide

29a, Certifier

4 - Homicide

(Check only one)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month Scan 4e. Facility Name (If not institution, give street eng 4b. City. Town, or Location of Death 4c. County of Death Year If Under 24 Hrs. 8. Da 5. Social Security Number 6. Sex If Under 1 8. Date of Birth (Month, Dey Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 216-80-330 Usuel Residence of Decedent 1 M 2004 Days Yrs. 22, 85 1914 Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3109 Offutt Road 21133 United States 11. Maritei Stetus 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced Specify White 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12)

9th Grade College (1-4or 5+) -0-Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Franklin Frederick Kirk Mary Louise List 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Margaret Davis - Sister 4406 Deer Park Road; Owings Mills, Maryland 21117 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 XBuriei 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lorraine Park Cemetery7/30/99 Woodlawn, Maryland 21. Signature of Funeral Service Licansee 22. Name end Address of Facility
Loring Byers Funeral Directors, Inc. 8728 Liberty Road; Randallstown, Maryland 21133 the disease, or complications that caused the lart failure. List only one ceuse on each line. ath. Do not enter the mode of dylng, such es cardiac or respiratory arrest, Approximate Interval Betw Onset and Death Immediate Cause (Finat disease or condition resulting in death) 10 year Due to ( es a consequenca of) 105cles Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or Injury that latitated executions) Due to (or es a consequença of) that Initiated events Due to (or as e consequença of) resulting In death) Lest Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death2 3 Probably 4 Frunknown 1 Yss 2 No 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes an eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yas 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending Investigation 1 Natural 2 Accident

**Physician** /Medical Examiner I or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and bir by the funceral director, page 2 should be deteched for use as the buriat-transit P.O. Box 68760,

of Vital Records,

Division

Physician/Medical Examiner Completed Be

**Physician** 

/Medical

Examiner

**Funeral** 

Director

must be notified at

28a-1

23a or

items ;

Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Intent of Health and Mental Hygiene. Intent 27 is marked other than "natural, or ite mry or other thaumatic event, I'm Medical Experime my or other thaumatic event, I'm Medical Experime.

permit. Pages I Department of H Importent: If ite any Injury or ot once.

Baltimore, Maryland 21215-0020

Directo

Funeral

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with the Maryland Show

death

þ Certification: To filled in by To the Hospital of within 24 hours a To the Funeral D Medicai

3 Suicide 4 Homicide 29a. Certifier (Check only

29b. Signeture end title of certifier

6 Could not be determined

1 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and piece, end due to the cause(s) and manner as stated. 2 Madical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and pleca, and due to the cause(s) and mainler as stated.

1 Yes 2 No

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29c. License number D0020964 29d. Dete signed (Month, Dey, Year) 07/29/99

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

Jerome H. Ginsberg, M.D. 8630 Liberty Plaza Mall Randallstown, MD 21133 31. Dete fited (Month, Day, Year)

Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)

State Registrar

JUL30



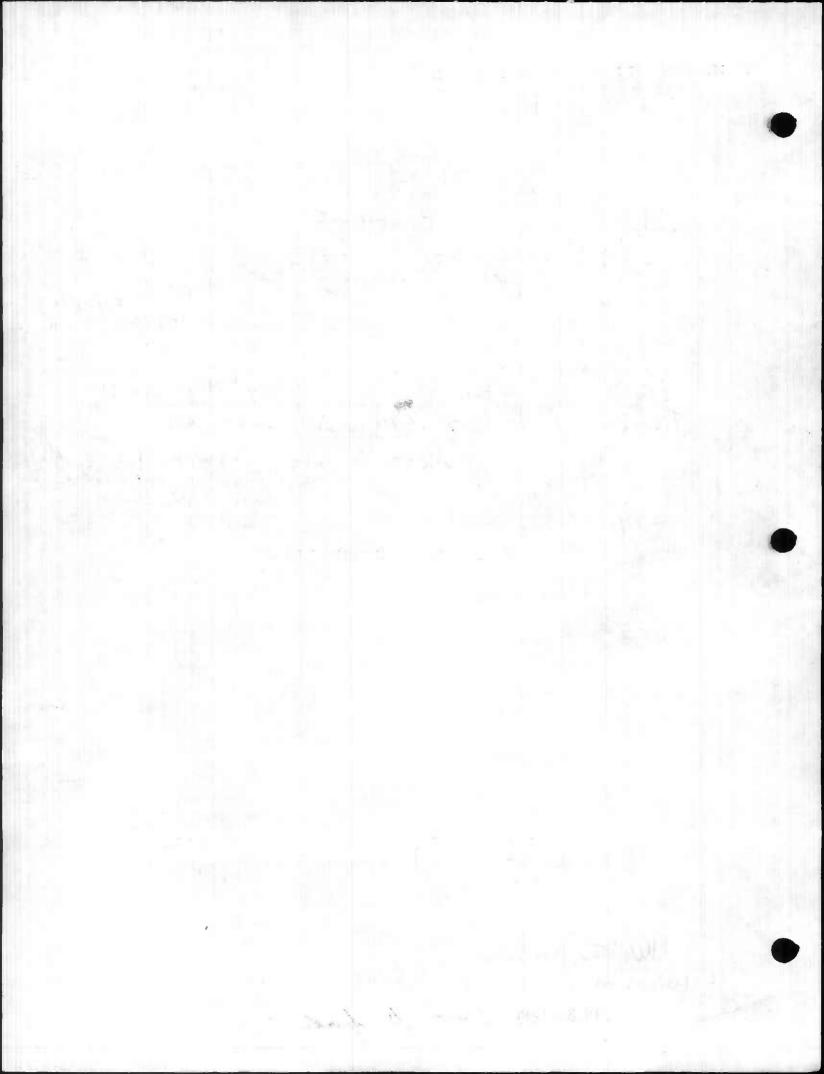
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State of	Maryland /	Department	of Health	and Menta	I Hygiene	99 1	2

Frank	Paul	110000	State of Marylar		nt of Health and			21.012
	AMEND ITEMS	5: #23 PART I, 27, 28A-F		1.10			Reg. No.	64016
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	Physician /Medical	Frank	Paul C	IK.			22, 1999	03:30 PM.
	Examiner	4a Facility Name (If not institution, give		,		r Location of Death	4c. County of	of Death
		5. Social Security Number 6. Se	rth Duncan St		Balti er 1 Year   If Under 24 H	more		N/A
	Funeral Director		7. Age (In yrs.	Yrs. Months			(, Year)	9. Birthplace (State or Foreign
		Usual Residence of Decedent				100	, 00	Jiw y jawa
	anylar ahow	10a. State 10b. County	10c. Ci	ty, Town or Location	-210			10d. inside City Limits 1 des 2 □ No
	vith the Maryla.  Tor 28s-f show be notified.	/VICI		Donis	1010			
	E 9 5	10e. Street and Number	Juncas 5+	L .	21217		10g. Citizen of W	mat Country?
	r items 23 other must	11. Maritai Status	12. Was Decedent Ever in U	I,S. 13. Was Dece	edent of Hispanic Origin? ecify Cuban, Mexican, Pue	(Specify Yes or No-	14. Race	- American Indian,
0	or ite	1 Never Married 2 Married	Armed Forces? 1 10 1es 2 □ No	if Yes, spe		erto Rican, etc.)		k, Whita, etc.
002	iraf. c	3 ☐ Widowed 4 12 Divorced	If Yes, Give Year or Dates:				Specify:	Black
5	ed within 72 hours tygiene. The then "natural" It, tre Medical Ex Completed by	15. Decedent's Ed (Specify only highest grad	ication le completed)	16a. Decedent's Usu (Give kind of w	ual Occupation ork done during most of w use retired)	orking UKN	16b. Kind of Bus	siness/Industry ULN
12	withir then the mo	Elementary/Secondery (0-12)	College (1-4or 5+)	III. DO NOT	use retired)			
p	tal Hyginal Hy	17. Father's Name (First, Middle, Last)	1 0		16. Mother's N	ame (First, Middle,	Maiden Sumame	θ)
lar	Menta Menta mrked atic av	Frank Pau	ISR.		May	~ HV	9h Sm	rith
Baltimore, Maryland 21215-0020	nd 2 should be filed within the and Mental Hyglene. 27 Is marked other than r traumetic avant, the Mr. To Be Comp	19a Informant's Name/Reletionship	ype, Print)	19b. Mailing Addres	is (Street and Number or	Rural Route Number	City or Town,	State, Zip Code)
6	Health Hen 27 I	Theresa to	int-driver	Place of Disposition (Na	U.COIIIN	gtan;	tve.	ma. To will be writed
10	or of	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	projectory, cramatory or	other place)	Date	O L/	City or Town, State
를	ritant ritant	4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Bervice Moent		METIO C	ind Address of Facility	1-30-4	balt	more my ku
Ba	Depart Bany L	10/1/ W/	1/2	22. Nome a	no Address or Pacinty	Jett 1	iller,	ference none
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	Physician	23a. Part1 Enter the disease, or comp shock or heart failure. List only of	ne cause on each line.					Intarval Batween Onsat and Death
	/Medical	Immediata Causa (Final disease or condition	SUBDURAL HEMAT	TOMA AND CIRRH	HOSIS OF THE LI	VER		
	Examiner	resulting in deeth)	8	or as a consequence of)				
	executed in and intransit Examiner		b					
. 6	be executed ician and burial-trans	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (d	or as a consequence of)	):			
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89	tificat as th	resulting in death) Last	200 10 (0	as a consequence of				
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	Attending Physician: The law requires that the death certificate or death.  sctor: After this certificate has been signed by the attending phys by the functal director, page 2 should be detached for use as the fill catlon: To Be Completed by Physician/Medic	Part II. Other significant conditions co	ntributing to death but not res	sulting in the underlying	cause given in Part f.	23b. Did 1	obecco uss con	tributs to the cause of death?
P.0.	hat the ad by detac					10	Y88 2□ No	3 □ Probably 4 □ Onknown
Division of Vital Records,	signed to be det					24a Was	an autopsy	24b. Were eutopsy findings
00	v requin					perfo	rmed?	available prior to complation of cause of death?
a e	The lay page 2					100	res 2 No	1 ☐ Yas 2 ☐ No
Ta .	certificate rector, pag	25. Wes case referred to medical			26. Place of D	eath (Check only o		12 140 22 110
>	Physician: this certific ral director, To Be	axaminar? 1 ☒ Yas 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3□ D	Other: 4 Nursing	Home 5 Resid	tence 6 Othe	ar (Specify)
0	After th funeral	27. Manner of Death 1 Natural 5 Pending	28a. Dete of Injury (Month, Day Year) Found:		28c. Injury at Work?		now injury occurre	ed
Sio	tal or Attending P rs after death. al Director: After ted in by the funers Certification:	2 Accident Investigation 3 Suicide 6 Could not be	7-22-99	3:15	1 ☐ Yes 2 ☒ No		T FELL	or or Burel Boute Mumber
Ö	or Attendent after deat Director:	4 ☐ Homicide determined	28e. Plece of Injury - At h building, etc. (Special	ome, rami, street, ractor by)	гу, опісв	City or Tov	vn, State)	er or Rural Route Number,
	Hospital     24 hours     Funeral I     Idetely filled	29a. Certifier 1 ☐ Certifying Phy	UNKNOWN sloten: To the best of my kno	owledge, death occurred	d at the time, date and pla	ce, and due to the		nner as stated.
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by Medical Certifi		ner: On the basis of axamina and manner stated.					
	To the vithin 2 To the comple	29b. Signature and title of certifier	Or.	29	9c. License number		29d. Date signed	(Month, Day, Year)
		Mayinte In	Wall		O.C.M.E.		July	23, 1999
		30. Name and address of person who o						
		MDCypnirs D. 19 31. Data filed (Month, Day, Year)			eet, Baltimo	ore, Mary	Land 212	201
1	State Registrar	JUL-80	32. Ragistrar's Signal	~ A	books.			
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**ORIGINAL** 



						Ce	rtificate	of L	Death		Reg. No.		
	Physici /Medi		Decedent's Name (First, Middle, La  CARL WERNE		OR JE	₹.				2. Date of De Month July	Day 25	1999	3. Time of Death 8:32P
	Examir		4e. Facility Name (If not institution, gir Stella Maris Ho		mber)			41	b. City, Town, or Timoniu	Location of Deat		of Deeth	00
-	Funeral		Social Security Number 6.	Sex	7. Age (In yrs	. last birthday)	If Under 1		If Under 24 Hrs			9. Birthol	ace (State or Foreign
_	Director			<b>XX</b> M 2□ F	81	Yrs.	Months D	)eys	Hours Min.	8. Date of Bir (Month, Da March 2	9,1918	Mary	Mand
Jand	M III		Usual Residence of Decedent  10a. State 10b. County		10c. C	ity, Town or Lo	ocation					10	Od. Inside City Limit
a Man	Tred	ctor	Maryland Baltimo	re	Lu	uthervi	lle						1 Yes XX
with th	De no	Director	10e. Street end Number	+ Carrat			10f. Zip Co				10g. Citizen of	What Coun	Iny?
THE STATE OF	78 23 Fresh	Funeral	215 Belmont Fores	12. Was Dec	edent Ever in I	U,S. 13.		093	spanic Origin? (S	pecify Yes or No	USA - 14. Rad	ce - America	an Indian.
THE PERSON NAMED IN	Department of Haalth and Mental Hygiena. Important: or items 23a or 28a-f show important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, tra Medical Examinat must be notified at 800cs.	þ	1 ☐ Never Married	Armed Fo 1/2/Yes If Yes, Gir Yeer or D	orces? 2 □ No WW ] ve oates:		if Yes, specify 1 □ Yes 2		n, Mexican, Puèri Specify:	pecify Yes or No o Rican, etc.)	Specif	ck, White,	
72 h	natu	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Dece	dent's Usuel C	occupe done d	tion uring most of wo	rking	16b. Kind of B	usiness/ind	lustry
filed within 72 hours after death with the Maryland	Hygiena. other than ent, tre Me	dwo	Elementery/Secondary (0-12)	College (	1-4or 5+)		erinte:				Cons	struct	ion
be filed	al Hyg	BeC	17. Fether's Name (First, Middle, Las				0. 200.		18. Mother's Nar	me (First, Middle	Maiden Sumar		
should b	Mental I	To	Carl Werner Pric							Christe			
2	Ith and 77 is me traum		19a. Informant's Name/Relationship Harriet D. Prior	(Type, Print)	Wife					Lutherv			
15   21	of Haalth item 27 I		20a. Method of Disposition			Place of Dispo cemetery, crer	sition (Name	of or piece	e)	Dete	20c. Location	- City or To	wn, State
Pagas	ant: If		1 ☐ Buriel 2XXX Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Speci		State	reenmou		,	-	//28/99	Baltimo	ore, N	Maryland
Demili	Department of Important: If it any injury or o		21. Signature of Funaral Service Lice	nsee /	1 -	22	2. Name end A	ddres	s of Facility Mi	tchell-Wi	edefeld F	uneral	Hame Inc.
			23a. Part1. Enter the diseasa, or com	en Men	ars					timore,		nd 212	
ł	nysiclan		shock, or haert failure. List only	one cause on e	ech line.	in. Do not em	er (rie mode o	i dyirig	, such as cardia	or respiretory e	rrest,		Approximete Interval Between Onset and Death
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Ce16 D	physic s tha b	edicai	thet initieted events resulting in death) Lest	Ç	Due to (	or es e conseq	uence of):			-			
death certifi	usa ak			d	· -								
1 deatr	the etta	Physician/M	Pert II. Other significant conditions of	contributing to de	eath but not re	sulting in the u	nderlying caus	se give	n in Pert I.	23b. Dld	lobacco use co	ntribute to	the causa of deat
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requires t	5 8	d by								24a. Wes	an autopsy		re autopsy findings
aw rec	s been s 2 should	Completed								perfo	med?	con	llable prior to nplation of cause leeth?
E C	ata ha paga	Com								1 🗆 '	Yes 2X No	1□	Yes 2□ No
Clan:	certificata rector, pa	Be	25. Was case referred to medical examiner?	Hospital:				Otho		ath (Check only o	one)		
Physician:	ral di	1: To	1 ☐ Yes 2 MNo  27. Mannar of Death	28a. Date		28b. Time of		Othe	4 LI Nursing P	lome 5 Resident	dence 6 X Oth		HOSPIC
Attending	death. ctor: Aftar y tha funer	atior	1 Natural 5 ☐ Panding 2 ☐ Accident investigatio	(Mon	th, Day Year)	Injury	м	Injury Work 1   Y	? ′es 2 □ No		, , , , , , , , , , , , , , , , , , , ,		
6	9 5 6	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Placa buildi	of injury - At h	nome, ferm, str ify)	eet, factory, of	ffice		28f. Location (a City or Tox	Street and Numi vn, State)	ber or Rurai	Route Number,
To the Bospital	within 24 hours ef To the Funeral DI complately filled in	edicai	29a. Certifier (Check only one)	niner: On the bi	best of my kn asis of examin- ner steted.	owledge, deeth stion and/or Inv	occurred et ti vestigetion, in	he time my op	e, date and piece Inion, deeth occu	, end due to the irred at the time,	cause(s) and modate and place,	anner as stand due to	ated. the cause(s)
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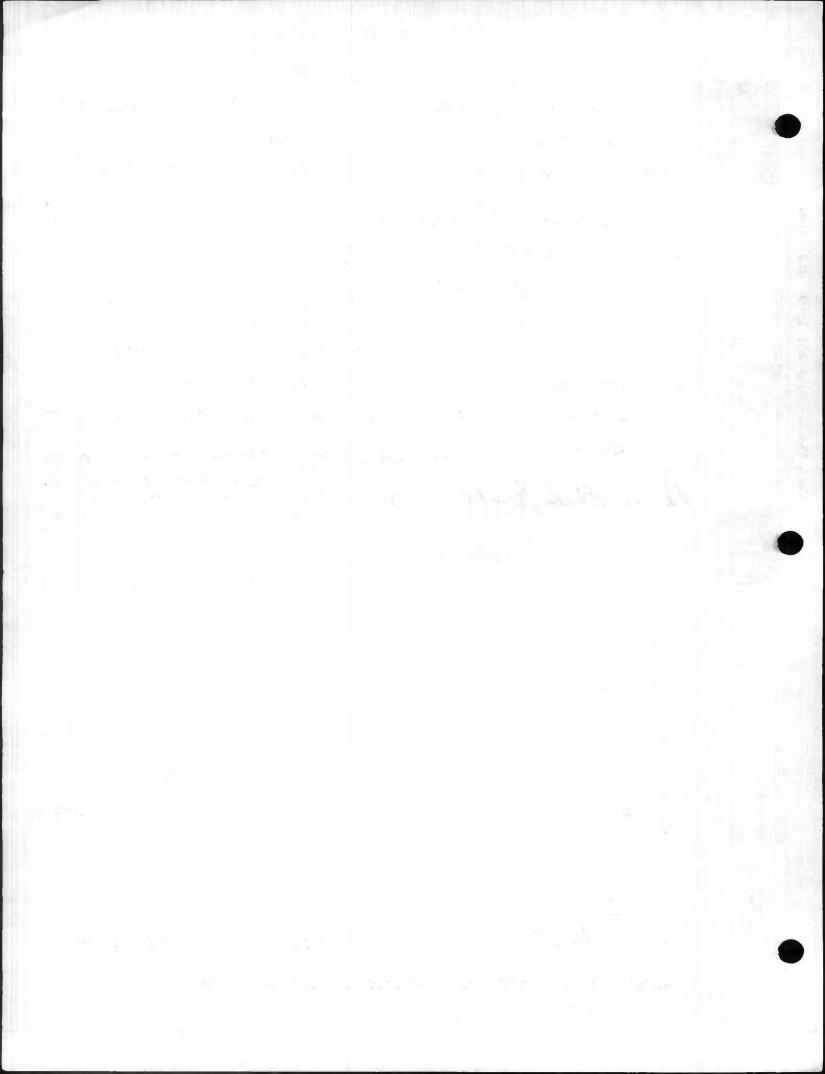
State

Registrar

8:32 р.ш.

July 25, 1999

CARL PRIOR



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month ALEEN, RHODES 3:43 AM JUL 1919 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death CENTER MEDICAL BALTIMORE, WD If Under 1 Year 7. Age (In yrs. lest birthdey) Birthplace (Stete or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Dey, Yeer) 1□ M 2**M** F Seventy-Fours Months Days Hours 213-22-1980 MARYLAND Usuel Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 1 Yes 2 □ No BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21029 GILBRIDE LANE 13615 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Giver Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. Black, White, efc. 1 □ Never Married 2 □ Married Specify: BLACK 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) GRADE WIFE NA HOUSE Home 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumeme) SAITHER INERUA nomas 19a. Informant's Name/Reletionship (Type, Print) Chughtek 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 1823 TACO 20b. Place of Disposition (Name of a cemetery, cremetory or other place) GREEN DELT CELESTE 20a. Method of Disposition MD 20770 Date 209 Location - City or Town, Stete 1 LZ Buria 2 ☐ Cremetion 3 ☐ Removel from \$tate MAREDI 4 □ Donation 5 □ Other (Specify) Em Funerel Service Lice ARCH 300 13AHO MD 21215 Dem rome AEVE WADASh Iter the disease, or complications that cause, the death. Do not enter the mode of dylng, such as cerdiac or respiratory arrest, rheart laiture. List only one cause on each rise. Approximate tntervet Between Onset and Death Immediate Gause (Finel disease or condition resulting in deeth) MYELOMA Sequentially list conditions, if any, leading to immediate ceuse. Enfer Underlying Cause (Disease or Injury that initieted events resulting in death) Lesf Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobecco use contribute to the cause of death? 1 Yes 26 No 3 Probably 4 Unknown 24b. Were eutopsy findings avaitable prior to completion of ceuse of deeth? 24a. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No 25. Was cese referred to medicel examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 12 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Naturai 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner es stated. 2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated.

certificate be executed P.O. Box 68760 Division of Vital Records. To the Hospital or Attending Physician: within 24 hours effer deeth.

To the Funeral Director: After this certificants the Funeral Director of the Fun

**Physician** 

'/Medical

Examiner

Director

Funeral

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Completed

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**Funeral** 

Director

7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours efter death v Department of Health and Mental Hygiene. Important: if flem 27 is marked other than "natural", or flems 23a and Injury or other treumatic event, the Medical Exercises 2006.

**Physician** 

/Medical

Examiner

attending physicien end for use as the burial-transit

certificate has

Physician/Medical Examiner

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Completed

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Certification: To

Medical

Baltimore, Maryland 21215-0020

the Marylend

State Registrar

**DHMH 16 Rev 6/95** 

31. Date filed (Month, Day, Year)

MORROW

30. Neme end eddress of person who completed ceuse of deeth (ttem 23e) (Type, Print)

29b. Signature and title of certifier

32. Registrar's

29d. Date signed (Month, Day, Year)

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AMEND #10e,17.19a&20a-22 PER F.H. G774 8-13-99 J.A. Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. AMEND ITEMS: #11, 17 PER F.H. G773 WR. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMENDED ITEMS #26 & #27 PER MD G773 7/30/99 AH Reg. No. 1. Decedant's Neme (First, Middle, Last) 2. Date of Death Physician /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death **Examiner** THE JOHNS HOPKANS HOSPITAL BALTIMORE CITY

If Under 24 Hrs. 8. Date of 8. Date of Birth (Month, Day, Year) Oct. 7, 1931 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 6. Sex Birthplace (State or Foreign Country) Funeral Days Hours 1□M 2X F Months 67 Yrs. Illinois Director 353-26-3986 Usuel Residence of Decedent 10a. Stata 10b. County 10c. City. Town or Location 10d, Inside City Limits 1 Yes 2 No Director Maryland Howard Fulton 10e. Street end Number 8548 8546 Reservoir Road 10f. Zip Code 10g. Citizen of What Country? deeth with ŏ 238 20759 U.S.A. Funeral 14. Race - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Peges 1 and 2 should be filed within 72 hours effer c Department of Health end Mental Hygiene. Important: If them 27 le marked other than "natural", or fren any Injury or other traumatic event, the Medical Examinations. 1 Never Merried 2 Merried 1 Yes 2 No If Yes, Giva Year or Detes: altimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: Specify: White p 3 Midowed 4 Ministreed Completed 16a. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) POTOCKI Potcki William F. Stella Kurg 19a Informant's Name/Reletionship (Type, Print) JACQUEL YN E. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Randall/daughter 8205 S.E. Harney #2, Portland, OR 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Buriel 2 MCremetion 3 ☐ Removel from State 4 ☐ Donation The Control of the C 21. Signature of Funagal Service Licensee EDWARD A. GREGORCHIK 22. Name and Address of Fecility
Ronald S. Wade Director State Anatomy By 7/21/99 BALTIMORE, MD 23a. Pet1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. State Anatomy Board State Anatomy Board, 655 W. Baltimore Street
Baltimore, MD 21201 SBEMATION SOCIETY OF MP TIMORE MD. 655 W Approximete Interval Between Onset and Deeth **Physician** /Medical Immediete Cause (Finel disaasa or condition resulting in deeth) · mitral valve disease Examiner Physician/Medical Examiner attending physician end for use as the burial-transit The law requires that the death certificate be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Undarlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of) Box 68760, Due to (or es a consequence of): P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown signed b Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Wes en eutopsy nerformed? 1 ☐ Yes 2 No 1 ☐ Yes 2 No Division of Vital Hospital or Attending Physician: 25. Wes case referred to medicat 26. Place of Deeth (Check only one) exeminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this filled In by the funeral 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Neturel 1 Yes 2 No death. 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner steted. 29e, Certifier To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar Maryland.

no completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

1990

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**DHMH 16 Rev 6/95** 

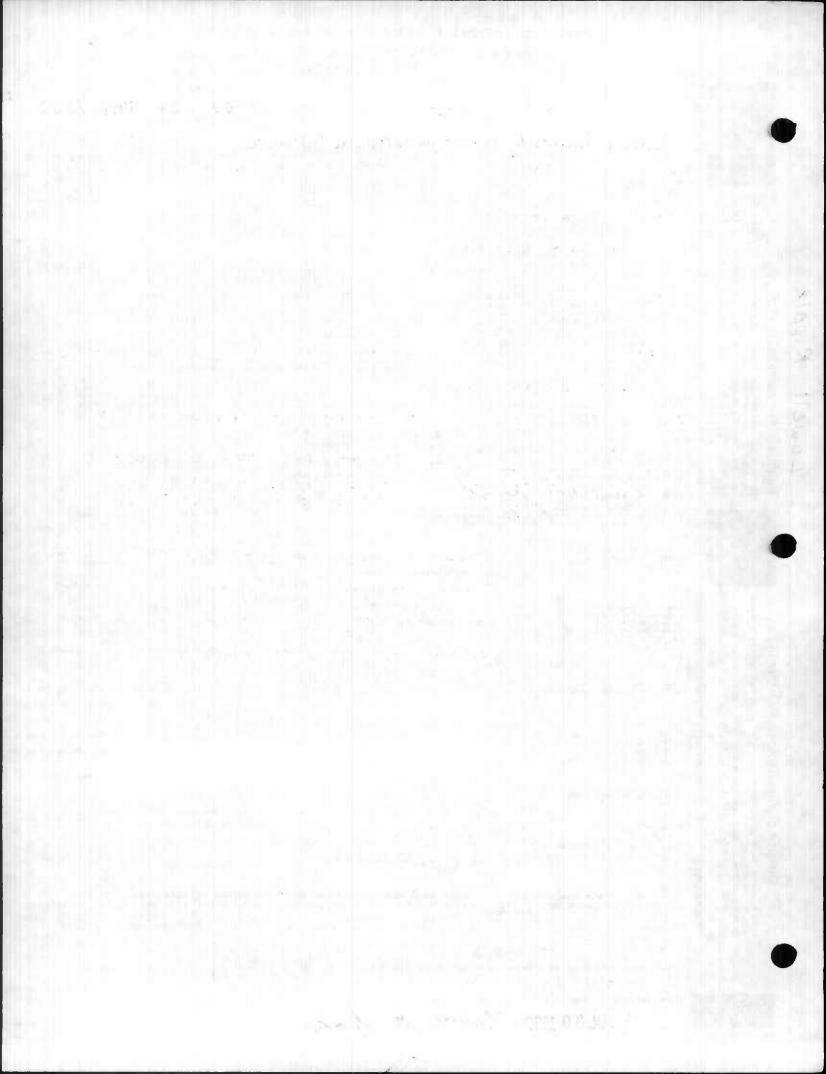
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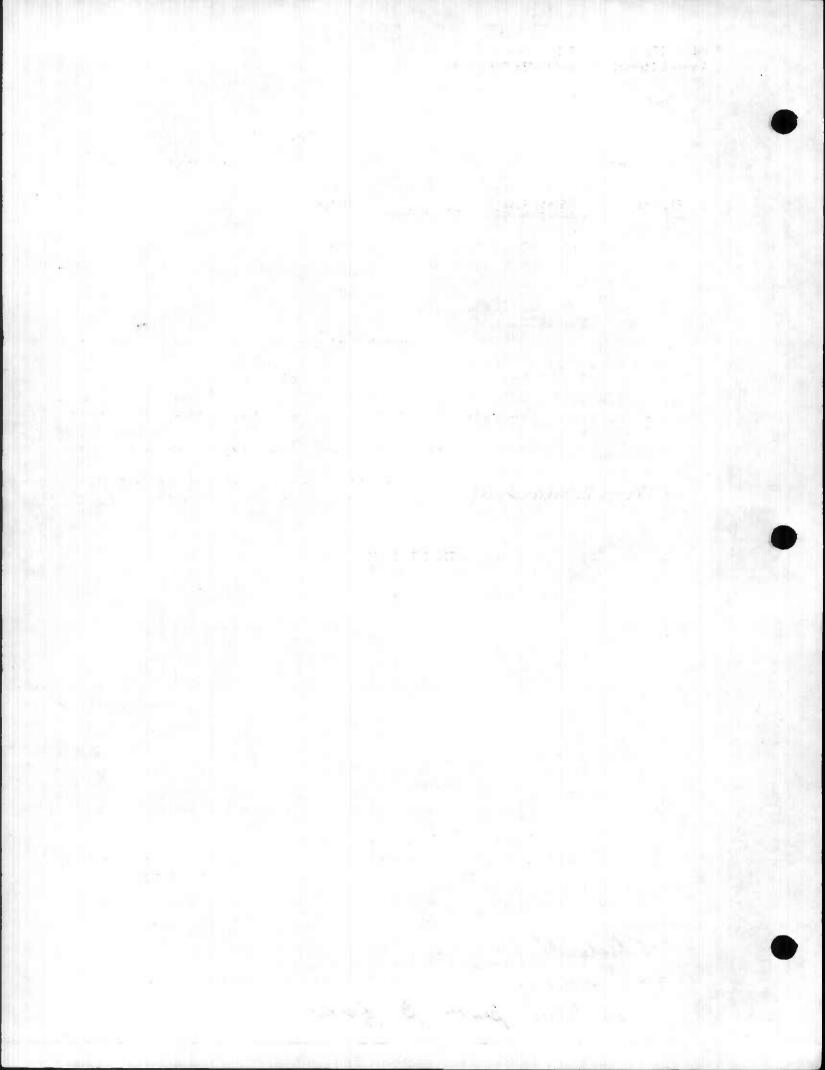
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32. Registrer's Signature

D. Sporks



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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Death 3. Tima of Death Eva R. Reamy 4b. City, Town, or Location of Death 99 4a. Facility Nama (If not institution, giva straat and number) 4c. County of Death Charlestown Care If Under 1 Yaar If Under 24 Hrs. 8. Deta of Months Days Hours Min. (Months) Center aftimore 5. Social Sacurity Number 8. Deta of Birth (Month, Day, Yeer) 05/27/1902 7. Age (In yrs. last birthday) Birthpleca (Stata or Foreign Country) 1 □ M 2 F Months 97 218-09-9977 Yrs. Usual Rasidanca of Decedant 10b. County 10a. Stata 10c. City, Town or Location 10d. Insida City Limits 1₺ Yes 2 No Baltimore Catonsville 10e. Street end Number 10f. Zip Coda 10g. Citizen of What Country? 709 Maiden Choice Lane 21228 USA 12. Was Dacedent Ever in U,S. Wes Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Mexican, Puarto Rican, etc.) 14. Raca - American Indian, Armed Forcas Black, Whita, atc. ∏Yas 2☐No f Yes, Giva 1 Navar Marriad 2 Married 1 ☐ Yas 2 🛣 No Specify: Specify: 3€DWidowad 4 □ Divorced Yeer or Datas: white 15. Decedent's Education (Spacify only highast grada complated) 16a. Decedant's Usual Occupation 16b. Kind of Business/Industry (Give kind of work dona during most of working lifa. DO NOT usa ratired) Elemantary/Secondery (0-12) Collega (1-4or 5+) U.S. Civil Service 10 Government 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumema) James Patience Rosie Schifel 19e. Informant's Name/Raletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) Dorothy Steyert/Daughter 3728 Mac Alpine Road/Ellicott City, Md21042 20a. Method of Disposition 20b. Place of Disposition (Nema of cematary, cremetory or other place) Data 20c. Location - City or Town, Stata 1 ☑ Burlal 2 ☐ Cramation 3 ☐ Removal from Stata Baltimore National 7/29 Baltimore, Md 4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signeture of Funaral Servica Licansae 22. Name end Address of Fecility Sterling Ashton Schwab Funeral Home, Inc maz k. Marshall 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. 21228 Approximata Interval Between Onset and Death Immediate Causa (Finel disaasa or condition rasulting in daath) a. End stage Congertive Heart failure Duro (or as a consequence of): YELL Sequantielly list conditions, if any, laading to Immadiata causa. Enter Underlying Causa (Disaasa or injury that initiated events resulting in deeth) Last Dua to (or as a consequence of): Due to (or as a consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara sutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yes 2 ☐ Mô 25. Wes casa rafarred to medical 26. Place of Daeth (Check only one) 1 Yas 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Magreer of Daath 28a. Data of Injury (Month, Day Year) 28b. Tima of Injury 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Neturel 5 Panding 2 Accidant Investigation 1 Yas 2 No 6 Could not be datarmined 3 ☐ Sulcide 28a. Placa of Injury - At home, farm, straat, fectory, office building, atc. (Specify) 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 4 Homicida

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Physician/Medical by Completed Be 2

**Physician** 

/Medical

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**Physician** /Medical

Examiner

filed within 72 hours efter death

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Baltimore,

Certification: Director: in by within 24 hours a To the Funeral D completely filled Medical

29a. Certifiar (Check only one)

Hospital

1 Cortifying Physician: To the best of my knowledge, death occurred at the time, data and plece, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, end due to the cause(s) and menner steted. 29b. Signetura and titla of cartifier

onth, Dey, Year)

29c. Licensa number

29d. Date signed (Month, Day, Year)

30. Name and address of person who commeted causa of death (Item 23e) (Type, Print)

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D 51051 July 27, 1999

Maiden closice Lane, Catorsville, MD, 21228 32. Registrer's Signeture Solgzar

Registrar **DHMH 16 Rev 6/95** 

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Please Type or Print In Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMENDED ITEM #22 PER FH G773 7/30/99 AH Reg. No. 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** HELEN REINHARDT 7:00 AM 1. FULL 28 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia Howard If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthdey) **Funeral** Months Days Hours 1 M 2 TF 90 489-01-1365 Yrs. Director Aug. 29, 1908 MO Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or flame 23a or 28a-f ahow the Medical Examiner must be notified at MD Howard 1 ☐ Yes 2 No Director Dayton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21036 U.S.A. 4940 Ten Oaks Road death Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. 12. Wes Decedent Ever in U.S. Armed Forces? filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White by 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Own Home permit. Peges 1 and 2 should be file Department of Health and Mental Hy important; if Item 27 is marked other eny Injury or other treumatic event 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph D. Smythe Anna Douchek 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leon J. Murphey (Son-in-Law) 13483 Open Space Court, Highland, MD 20777 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 8/2/99 St. Louis, Missouri Calvary Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22. Name end Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Oaks Road, Columbia, Maryland 21045 23e. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervat Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) ATHEROSCLEROTIC CANDIOVASCULAR DISTISE Due to (or es e consequence of) Examiner The lew requires that the deeth certificate be executed Due to (or es e consequence of): and Sequentially list conditions, if any, teeding to immediate cause. Enter Underlying Cause (Disease or Injury) physician Physician/Medical tribute to the cause of death? á 3 Probably 4 Dunknown signed be del

**Physician** /Medical Examiner

aitimore, Maryland 21215-0020

þ Completed 8 Certification: To I Director: After death.

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To the Hospital or A within 24 hours after To the Funeral Directompletaly filled in by

or Attending

Division of Vitai Records, P.O. Box 68760

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DEMENTIN	1 Yes 2 No

24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 100 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Naturel 5 Panding Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28e. Plece of Injury - At home, lerm, street, lectory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

29a. Certifier 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated. (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year)

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D 51960

3460 ELLICOTT CTR DR #103 ELLICOTT CIM MD 2/043 MD JUNATHAN

State Registrar

Medical

31. Dete fited (Month, Dey, Year)
JUL 3 0 1999

32. Registrer's Signeture

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Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 23:33 26 Raymond E. Steffey, Sr. July 4b. City, Town, or Location of Beath 4a Facility Name (If not institution, give street end number) 4c. County of Death Union Memorial Hospital Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (Stete or Foreign Country) Months Days Hours XXM 2 F 77 Yrs. 215-16-0447 Nov. 12, 1921 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits YN Yes 2 □ No Maryland N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6203 Hilltop Avenue 21206 USA 12. Was Decedent Ever in U,S. Armed Forces? X ☑ Yes 2 ☐ No If Yes, Give 14. Raca - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes XX No Specify: Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced white WWII 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Phillips Brother Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Warehouse, Inc. 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) Raymond R. Steffey Vashti Collins 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Vivian E. Steffey Wife 6203 Hilltop Avenue Baltimore, Maryland 21206 20b. Place of Disposition (Neme of cemetery, cremetory or other pleca) 20a. Method of Disposition Date 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State Maryland Veteran Cemetery 7/30/99 Garrison Forest, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland 21211 Denlei is thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, these on each line. Approximate Interval Between Onset and Death Immediate Cause (F MyDeardia 13 days disease or condition resulting in death) ardiogenic Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Last Due to (or as a consequenca of): Arrhythmia Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of pleath? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy tindings available prior to completion of cause of death? 24e. Wes en eutopsy 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Wes case referred to medical 26. Place of Death (Check only one) Hospital: 1 Napatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Sulcide 6 Could not be determined 28e. Pleca of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide

law requires that the death certificate be executed and the burial-tran use as ate has been signed by page 2 should be detac After this certificate director.

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

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permit. Pages 1 and 2 a Department of Health ar Important: If Itam 27 is any Injury or other trau once.

**Physician** /Medical

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Certification:

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altimore, Maryland 21215-0020

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Steffey, Raymond

State Registrar

John

MD

29d. Date signed (Month, Dev. Year)

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

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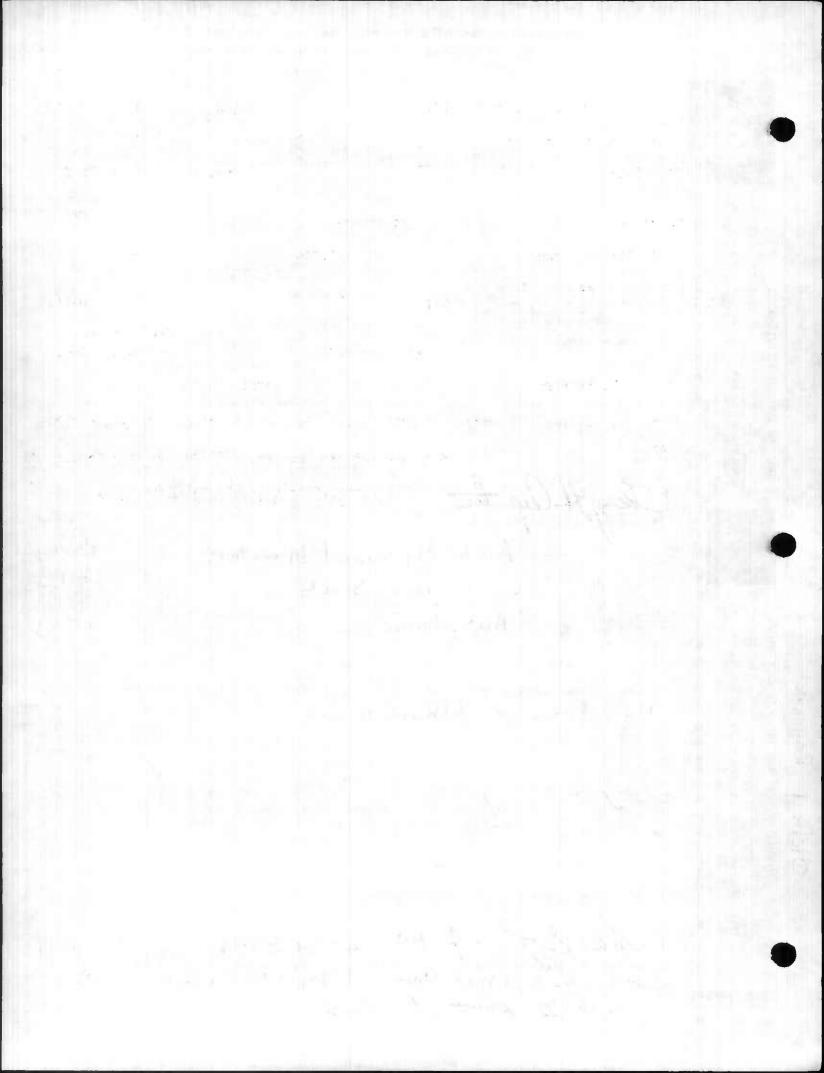
1 Certifyting Physician: To the best of my knowledge, deeth occurred et the time, dete and place, and due to the ceuse(s) end manner es stated.
2 Medicat Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

31. Dete filed (M

29b. Signature and title of certifier

32 Registrer's Signeture



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dey 28 Rebecca Sykes 0109 07 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BAUTIMORE BALTHORE UMMS (174 If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 218-36-8692 Usuat Residence of Decedent 1 M 2 F Months Vlarch 23,194 10b. County 10d. Inside City Limits 10c. City, Town or Location Maryland 15 Yes 2□No mor 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 2 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race -American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced 0 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Sumama) Informant's Name/Relationship (Type, Print) HUSBAND 19b. Mailing Addr uaene 0 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremetion 3 □Removel from State 4 ☐ Donation 5 ☐ Other (Specify) reenmoun remator 22 Name and Address of Facility JOSEPH L. RU 21. Signature of Funeral Service Liour 5 ral. un HUE. 22 North salto. 1210 23a. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate tritervat Between Onsat and Death tmmediata Cause (Final disease or condition resulting in death) Ex Sanguination Due to (or as a consequence of) tem vas u a on Glover ext OPEN MOUND bypass SUMPERY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Perspheral Vased an disease Due to (or as a consequence of): Ity pertension Part It. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown will disease (eny 01/01/19 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 280 No 1 Yas 1 Yes 2 No

Physician /Medical Examiner

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Box 68760,

Division of Vital Records, P.O.

**Physician** 

Examiner

10a. State

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**Funeral** 

Director

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pernit. Pages 1 and 2 should be illed within 72 hours after d Department of Health and Mentel Hyglene. Important: if Nem 27 Is marked other than "natural", or iten any injury or other treumatic event, are Medical Examinal.

Baitimore, Maryland 21215-0020

by Funeral Director

Completed

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/Medical

Physician/Medical Examiner use as the buriel-transit To the Hospital or Attending requestion 24 hours after death.

To the Funeral Director: After this certificate has been signed by the exampletely filled in by the funeral director, page 2 should be detached? Š Medical Certification: To Be Completed

25. Was case referred to medicat 26. Place of Death (Check only one) axaminer? 12(Yes 2 No Hospitat: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 31 DOA 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 E Natural 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Yas 2 No 2 Accident 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1. Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.
2. A second Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29c. License number

04585

22 S. Greene St

29d. Date signed (Month, Day, Year)

28/99

State Registrar

31. Data filed (Month, Day, Year) 3 0 1999

(Check only one)

29b. Signature and title of certified

D) ye

UNIVERSITY 32. Registrar's Signatura

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUL **DHMH 16 Rev 6/95** 

1440

HOSPITAL

				State of M	•	epartment of r Certificate of			Reg. No.	9 2	4022				
	Di di		1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month		Year	3. Time of Death				
	Physici /Medic		MERRITT T. SMITH,	JR.				July 2			8:00 p.m.				
	Examir		4a Facility Neme (If not Institution, give st	-			4b. City, Town, or L		4c. County	ol Death					
			Greater Baltimore				Baltimo,		N/A						
	Funeral Director		103-10-3080	M 20 F 8	ge (In yrs. last birth	nday) If Under 1 Year Months Days	Hours Min.	8. Date of Birth Month, Day Oct. 22	Year) 910	_Country	ylvania				
	yland Now		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location				10d.	. Inside City Limits				
	with the Marytar a or 28a-f show be notified at	ctor	Maryland Baltimo	re	Baldw	in					1 ☐ Yes 2 ☒ No				
	0 23 0 23 0 23	Director	10e. Street and Number			10f. Zip Code		1	10g. Citizen of W	/hat Country	?				
	23s	0.775	13718 Baldwin Mil	2 Road		2101	3		U.S.A.						
120	hours after de ursi', or items al Examiner m	by Funeral	11. Merital Stetus  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Wes Decedent Armed Forces?  1 X Yes 2 1 If Yes, Give Year or Dates:	No	13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 10 No	pecify Yes or No- o Rican, etc.)	14. Race Black Specify:	e - American k, White, etc						
9			15. Decedent's Educe	etion	169 [	Decedent's Usual Occup	pation		16b. Kind of Bu						
21215-0020	d within 72 giene. r than "nat	Completed	(Specify only highest grede Elementary/Secondary (0-12) 8th grade	completed) College (1-4or !	5+)	Give kind of work done life. DO NOT use retire	during most of world)	king	Armoreo						
Pu	A Stille	Be	17. Father's Name (First, Middle, Last)					ne (First, Middle,		9)					
yla	Ment Ment arkse	2	Merritt T. Smith,				Harries	t (Unknow	vn)						
Maryland	2 sh and is m		19e. Informent's Name/Relationship (Typ			Meiling Address (Street									
-	ages 1 and int of Health t: If Nem 27 y or other to	ŀ	Linda Smith Pocius 20a. Method of Disposition	, (vaugn		3718 Baldwi			20c. Location		1013				
altimore			1 ⊠ Burial 2 □ Cremation 3 □ Re	moval from State		Disposition (Name of , cremetory or other ple									
=	The second		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licenses	1.00	Highvi	ew Memorial									
B	Dep Person		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, MD. 21014												
			23a. Part1. Enter the disease, or complic shock, or heert feilure. List only one	ations that caused cause on each li	d the death. Do no ne.	ot enter the mode of dyi	ng, such as cardied	or respiretory and	rest,	Ain	pproximate iterval Between				
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in deeth)  Onset and 1  4 do 4												
		liner													
,	execute in and ial-tran	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	7	Due to (or as e co	onsequence of):	utin			1	4 days				
68760,	icata be executed physician and s the burial-transit	edical	Ceuse (Disease or injury that initiated events resulting in death) Last		Due to (or as a co		12170		-		1. 10				
_			d.												
Вох	death certif e attending ed for use a	clar	Don't Other significant and distance and	the air a decade h			'- P1	ODE DIA		4-10-10-10-10-10-10-10-10-10-10-10-10-10-					
, P.O.	the the	by Physician/M	Part ii. Other aignificant conditions control  Seventra				/en in Paπ I.	1	res 2 No		bly 4 Unknown				
of Vital Records,	law requires that as been signed b 2 should be dete	Completed b	Benentia Chame O	astruc	five L	my Dr		24a. Was a perfor	an autopsy med?	availa	autopsy findings able prior to eletion of cause ath?				
Re	0 - 6	E						101	as No	101	\/				
ta	certificate	BeC	25. Was case referred to medicel				26. Place of Dea	ith (Check only or							
<b>1</b>	5 m 10	ToB	examiner?	spital:	ent 2 ER/Outp	patient 3 DOA Ott	vov.	ome 5 Resid		or (Specify)					
0 0	ding Phy h. After this funeral		27. Manner of Death 1 Naturel 5 Panding	28a. Date of Inju (Month, De		ury Wo		28d. Describe h	ow Injury occurr	ed					
Sio	Attending I or death. ector: After by the funer	cat	Accident investigation  3 Suicide 6 Could not be	On Division Line	4.1		Yes 2 □ No	206 Leastine (F	Supplement Alices to	on on Devent C	South Atumber				
Division	after after Direct Jin by	Certification:	4 Homicide determined	building, et	c. (Specify)	n, street, factory, office		City or Tow	itreet end Numb n, Stete)	er or Hurai h	oute Number,				
	To the Hospital or Attend within 24 hours after deati To the Funeral Director: completely filled in by the	edicai C	29e. Certifier (Check only one)	cian: To the best or: On the basis of and manner sto	f examination and	deeth occurred at the til or investigation, in my o	me, date and place prinion, deeth occu	, and due to the orred at the time, o	ause(s) and ma dete end place, a	nner as state and due to th	ed. e cause(s)				
	To th Vithin To th	Me	29b. Signeture end title of certifier	mbo	mo	29c. Licens	1255 A	4	29d. Date signed	Month, De	y, Year)				
		-	30. Name and address of person who com	pleted cause of d	leath (Item 23a) (7	go. Pris chal	y ED.	Hunt	Vally	mD	21030				
	Sta Registr	_	31. Date filed (Month, Dey, Year)  JUL 3 0 1999	32, Registr	ar's Signature	Soa V	, :								

DHMH 16 Rsv 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** ESSIONS EONARD 13:54 /Medical 4a Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner JUHNS HOPKINIS 8. Date of Birth (Month, Day, Year) N/A HOSPITAL H Linder 1 Vee 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 212-74-7559 10XM 20 F Director 44 11-24-54 MD. Usual Residence of Decedent 10a, Stata 10b. County 10c. City, Town or Location show 10d. Inside City Limits MD. N/A BALTIMORE Director 1 XYes 2 No 288-1 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Nems 23s or 719 E. 20th ST. 21218 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexicen, Puarto Rican, etc.) 14. Race - Amaricen Indian, Black, Whita, etc. filed within 72 hours after 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Datas: 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 8 1 Yes 2 XNo Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent'a Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) -12--0-LABORER CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother'a Nama (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental LENORD SESSIONS SR. IDA THOMPSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ä if them 27 is or other tra IDA THOMPSON (MOTHER) 719 E. 20th ST. BALTIMORE, MARYLAND 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removal Irom State 4 Donetion 5 Other (Specify) MT. ZION CEMETERY 8-2-99 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licenses 22. Nama and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or haart lailure. List only one ceuse on each line. Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Septic Shock d weeks Examiner Due to (or as a consequence of) The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last pue Due to (or es a consequence of): physician s the burial Box 68760. by Physician/Medical Due to (or as a consequence of) for use P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown hepatic failure secondary Records, 24b. Ware autopsy lindings available prior to completion of cause of death? Completed cirrhosis, HIV 24a. Was an autopsy performed? 20 No 1 TYes 2 No Division of Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 Inpetient 2 ER/Outpatient 3 DOA Medical Certification: To 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) Inneral 27. Mannar of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury st Work? 5 Pending investigation 1 Neturel To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29e. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and titla of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MARYLAND ROTHMAN, JOHNS HOSPITAL HOPKINS

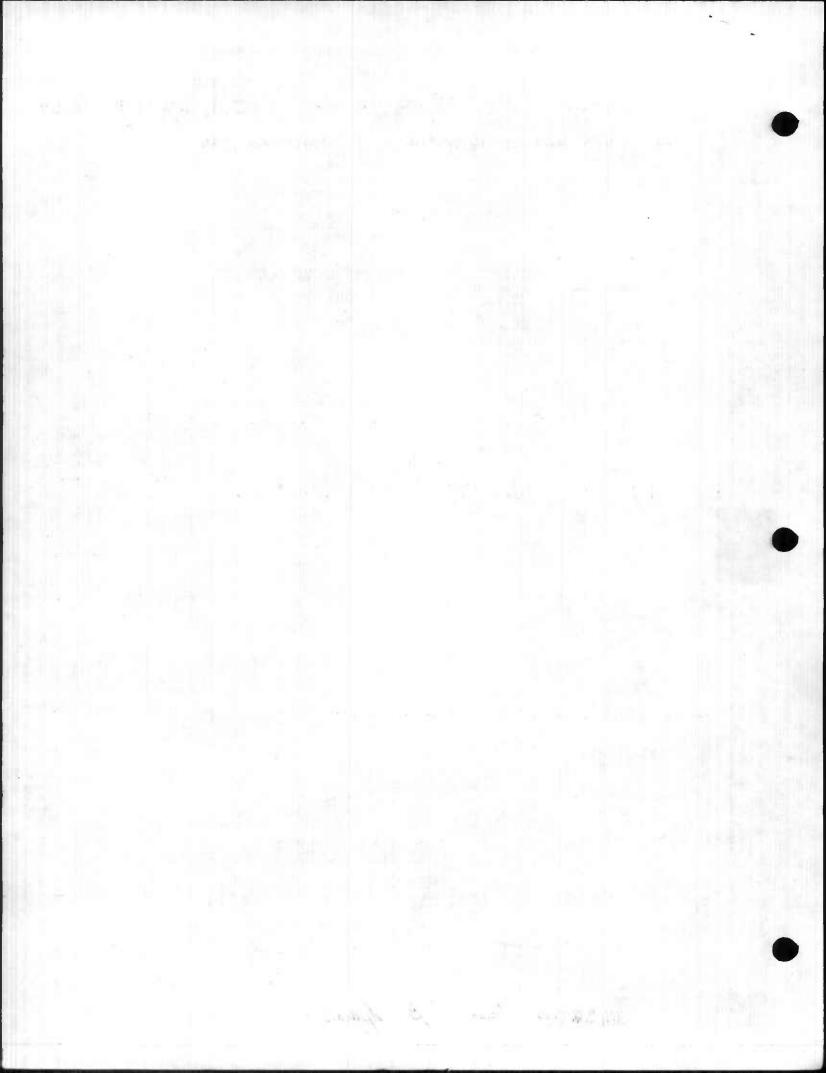
Registrar

State

31. Date liled (Month, Day, Year)

oaks

32 Registrar's Signature



			nai yidi		rtificate of		d Mental Hy	Reg. No.	3 240		
nysician	1. Decedent's Nama (First, Midd						2. Data of Do Month		Vear	na of Death	
Medical	Roland Linfield					41. O'4 : T-	JULY or Location of Deal	-	1999 2	.30 am	
kaminer	4a Facility Name (If not institution GOOD SAMA)		•	ITAL			1 MORE				
and l	5. Social Security Number			. last birthday)	If Under 1 Year				ore City  9. Birthplaca (S	tata or Foreign	
neral ector	215671708		87	Yrs.	Months Days	Hours N	lin. 8. Data of Bi (Month, D. Mench 2)	1912	Baltimore,	Maryland	
	Usual Residence of Decedent								,		
notified at frector	10a. Stata 10b. County			ity, Town or Lo						da City Limits	
otims ecto	Maryland Baltimo	re	Balt	imore Co	,			40 000 60		Yas 2 No	
늄	10e. Street and Number 9125 Avondale Road	1			10f. Zip Code 21234			10g. Citizen of	what Country?		
9.0	11. Marital Status	12. Was Deceden	t Ever in L							an.	
by Funeral Directo	1 Never Married 2 Man 3 Widowed 4 Divorces	Armed Forces  1 Yes 2 K	? No		If Yes, specify Cub 1☐ Yes 2☐XNo		uarto Rican, atc.)	Bia Specif	ck, Whita, atc.		
	15. Decede	nt's Education		16a. Deced	dent's Usual Occu	pation	. 4 %	16b. Kind of B	usiness/Industry		
Completed	(Specify only higher Elementary/Secondary (0-12)	est grada completed)  College (1-4or	5+)	tife.	DO NOT use retire	d of work done during most of working NOT use retired)					
Con		College (1-4or		Tool &	Dye Maker				Proving G	rounds	
e	17. Father's Neme (First, Middle,						Nothar's Neme (First, Middle, Maiden Surname)				
2	David Fligene Shack						Le Mabel Fritzsche er or Rural Routa Number, City or Town, State, Zip Code)				
	19a. Informant's Name/Relation Etta L. Shackelfor			Rural Routa Numb		, State, Zip Code)					
	20a. Mathod of Disposition	··· (1110)	20h	Place of Dispo	osition (Nama of		Data		- City or Town, Sta	ite	
	1 X Burial 2 ☐ Cremation			cemetery, crer	matory or other pla						
-	4 ☐ Donation 5 ☐ Other (5		PDE		metery Jul 2. Nama and Addre		3	DALLIIDIC	e, Maryland		
Series Series	26-11		Inc								
	23a. Part1. Enter the disease, o	Soho Chor	COK!	th. Do not ent	401 Belair	Road Bal	Inc timore, Mar	yland 212	236-4625	ximata	
n	shock, or heart failure. Lis	t only one cause on each	line.	ur. Do not on	ar are mode or dy	ing, sauri de our	sido oi idopiidioty e	111001,	Intarva	and Death	
n ai	Immediata Causa (Final	OC 11	50 m		E00.0				48 - 1		
r	Immediate Cause (Final disaase or condition rasulting in death)  SEVERE SEPSIS  Due to (or as a consequence of):										
Jer		D. PELI	,								
ami	Sequentially list conditions.	b. 12 L	Due to (	or as a conseq	quence of):						
cal Examiner	Sequentially list conditions, if any, leeding to immediata cause. Entar Underlying Cause (Disease or injury	PERI				OLD	DIVER	TICUL	uni		
dica	cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Lasi  Due to (or as a consequence of):										
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lan											
Physician/Me	Part II. Other significant condition	CAN A - LEGISLA IN THE CAN		sulting in the u	nderlying causa gi	ven in Part I.			ontribute to the ca		
h Ph	COR PUL	MONALE					10	Yee 2□No	3 Probably	4 Unknown	
pd by								s en autopsy	24b. Were auto	ppsy findings	
Completed								ormed?	available p completion of death?	orior to n of cause	
dmc							40	Yas 2 No	1 Yas	2000	
	25. Was case referred to medica	N				26 Place of I	Deeth (Check only		TLI TAS	C) A NO	
0	axaminer?	Hospital:	ient 2	ER/Outpatien	N 3 DOA OU	her	g Homa 5 ☐ Ras		har (Specify)		
n: T	27. Manner of Death	28a. Date of In	ury	28b. Tima of				how injury occur		147	
atio	Natural 5 Pendii 2 Accident invest	rig (Month, D	ay rear)	Injury		rk? ]Yes 2□No	1776				
Certification:	3 ☐ Suicide 6 ☐ Could determ	not be nined 28e. Place of Ir building, e	njury - At h	nome, farm, str	reet, factory, office		28f. Location ( City or To	(Street and Number, Stata)	ber or Rural Routa	Number,	
edicai 0	29e. Certifier (Check only one) Certifyli 2 Medical	ng Physician: To the best Examiner: On the basis of and manner s	of axamina	owledge, death ation and/or inv	n occurred et the ti vestigation, in my o	me, date and pla opinion, deeth o	ace, and due to the courred et the time,	cause(s) end m dete and place,	enner as stated. and due to tha ce	use(s)	
×	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)										
	DANU GABA	MD.	The	gou	P	125	60	JUL	1 27	× 1999	
	30. Nema end addrass of person	who completed cause of	death (Item	(Type,							
	ANU GABA,	RESIDENT	- , a	OOD	SAMAI	RITAN	HOSPI	TAL BI	9LTIMOI	RE 21239	
State	31. Data filed (Month, Day, Year,	32. Regist	trar's Sign	atura				1			

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3 Time of Death Day Yaar **Physician** ARMEN A, 1600 STROLLO 1999 /Medical 4a Facility Nama (If not institution, giva street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner 140 SP; +A HUrch Home 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foraign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 100M 20 F Months Days Min. Hours 144-22-6123 Director NOV 27, 1928 Usual Rasidence of Decedent 10s. State 10b. County 10c. City. Town or Location 7 is marked other than "natural", or items 23s or 28s-( show traumstic avent, the Medical Examinar mass to notified at 10d. Insida City Limits 1 PYas 2 No Director BAltimore 10e. Street and Number 10g. Citizen of What Country? 1008 U.S.A. 2120 Funeral 12. Was Decedent Ever in U.S.
Armed Forces? Norce N
1 [Prys 2] No
It Yas, Give
Year or Dates: 1952 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) Race - American Indian, Black, White, atc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental hygiene. Important: if item 27 la marked other than "natural", or hen eny injury or other traumatic avent, the Heddel Emirman 1 Never Married 2 Married 1□Yes 217 No Baitimore, Maryland 21215-0020 Specify: P 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dept of Transporation RePairMAN 1 % NIA 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) Voseph Strollo ANNA Muyolie 19a. Informant'a Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) JR. PO BOX 765 Carmen Strollo OCCAN view Del 19970-0765 20c. Location - City or Town, Stata 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 7/30/99 1 Burial 2 □ Cremation 3 □ Removal from Stata Baltimore Karkwood Cemeter 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Facility DELLA NOCE & SONS FUNERAL HOME 21. Signature of Funeral Service tycenses 322 S. HEAK ST. BAGO 21202 7/4. 23a. Part. Entar the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, about, or heart failure. List only one cause on each line. Approximata Interval Batween Onset and Death **Physician** Immediate Cause (Final diseasa or condition resulting in death) URNSEPSIS /Medical dayo Examiner Physician/Medical Examiner attending physicien and for use as the burlei-transit certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to for as a consequence of): P.O. I signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Records, Be Completed by 24b. Were autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 DANO Division of Vital or Attanding Physicien: after death. 25. Was case referred to medical 26. Place of Death (Check only ona) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yas 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To After this funeral 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending invastigation 1 Naturat ours after death. erel Director: Aft filled in by the fur 1 Yes 2 No 2 Accident 6 Could not be detarmined 3 Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funerel D completely filled it 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and manner as stated.

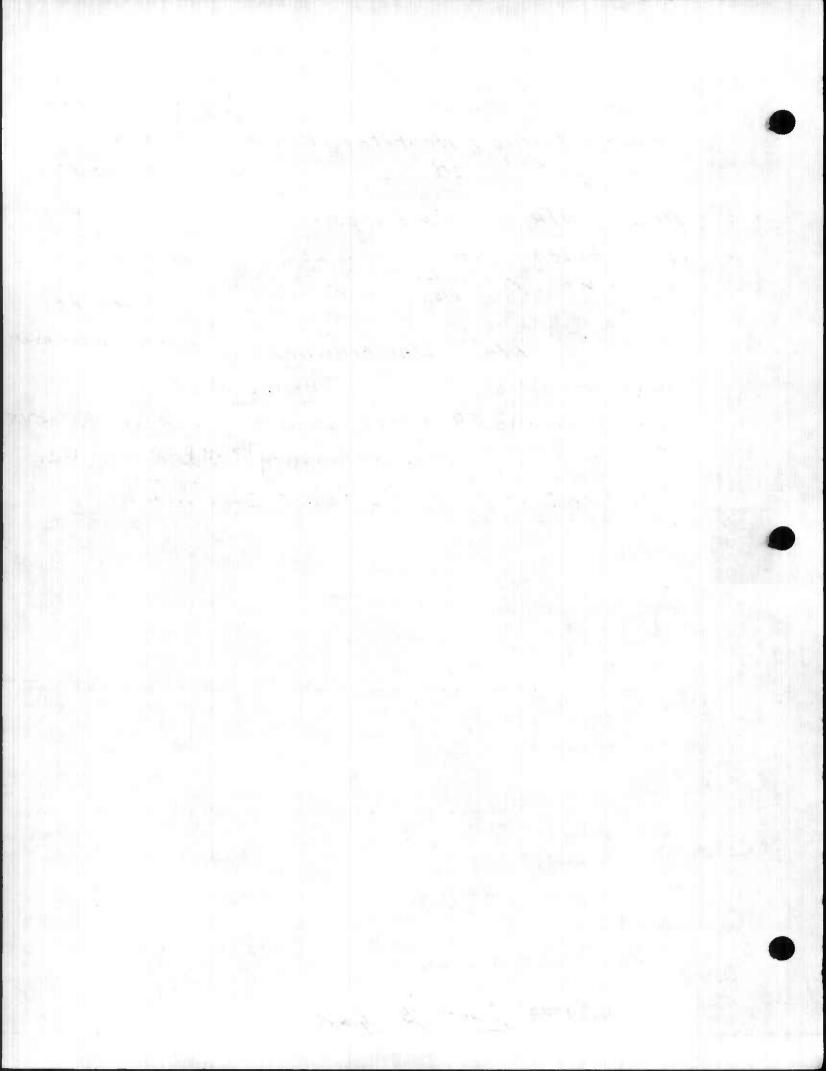
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and titla of certifier 29c. License number 29d. Data signed (Month, Day, Year) 40356 Ul avary my Specialis 30. Nama and addrass of person who completed cause of death (flem 23a) (Type, Print) Baltimore, Hangland 100 N. Broodway WENGUSAT. NAVARRO MD

**DHMH 16 Rev 6/95** 

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signatura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2025 IchArd Shicke 2 u 4e Fecility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 8. Dete of Birth (Month, Day, Year) 36-C Cro S If Under 24 Hrs. tOL neeview Birthplaca (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Days Min t M 2□ F Months Hours Country)
Illinois 134-12-9530 85 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Anne Arundel Crofton 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1836 Treeview Court, Apt. 21114 USA 12. Wes Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. Yes 2 No 1 Never Married 2 Married 1 Yes 2 No Specify: White Specify: 3(☐Widowed 4 ☐ Divorced Yeer or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 4 Admissions Counselor Business School 18. Mothar's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) James B. Shickel Fannie M. Hewitt 19a. tnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) David O. Shickel (Son) 1725 Mayfair Place, Crofton, MD 21114 20b. Placa of Diaposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 

Burial 2 □ Cremetion 3 □ Removel from State Oakwood Cemetery 07/31 4 ☐ Donation 5 ☐ Other (Specify) Syracuse, NY 21. Signature of Funeral S 22. Nama and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 the mode of dying, such as cardiac or respiratory arrest, Appro 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or haart failure. List only one cause on each line. teart Failure Immediate Cause (Final estive disease or condition resulting in death) Dua to (or as a consequence of) Sequantially list conditions, if any, laading to immediata cause. Enter Underlying Causa (Disaasa or Injury that Initiated evants resulting in death) Last Due to (or as a consequenca of): Due to (or as a consequence of) 23b. Did tobacco use contribute to the causs of death? Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveitable prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was casa rafarrad to medical 26. Piaca of Death (Check only one) xaminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. tnjury at Work? 28b. Time of 28d. Describe how Injury occurred 1 Naturai 2 Accident 5 Pending investigation 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

physicien end s the burial-transit The law requires that the death certificate be executed P.O. Box 68760. 80 for use es signed by the e peeu certificate has t Attending Physician: director this funeral After

Examiner Physician/Medical by Completed Be 2 Certification:

4 Homicide

(Check only

29a. Cartifian

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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**Funeral** 

Director

the Maryland

Fages 1 and 2 should be filed within 72 hours after death with the Mandan and Chatth and Mental Hygiene.
The file of the marked other than natural; or items 23a or 28a-f show the transition of other than chatter of the Mandal Exercise made to provide a style or other transitions.

important: any injury o

**Physician** 

/Medical

Examiner

altimore, Maryland 21215-0020

Division of Vital Records, in 24 hours after deeth. To the Hospital o within 24 hours aff To the Funeral Di completely filled in

> State Registrar

edical

29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, daath occurred at the tima, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the tima, data and place, and due to the cause(s) and manner stated. eputy

29c. License number

29d. Date signed (Month, Day, Year)

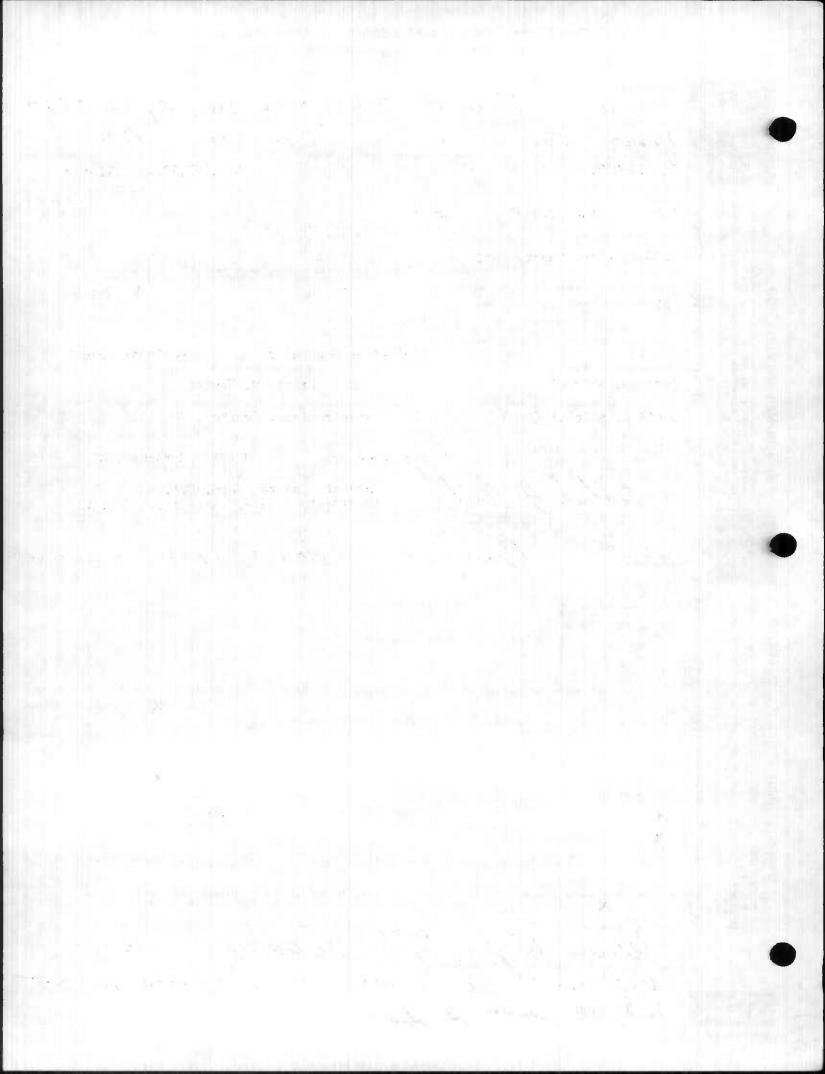
30. Name and address of person who comply

cause of death (Item 23a) (Type, Print) DNES

31. Data filed (Month, Day, Year)
JUL 3 0 1999

32. Registrar's Signature

**DHMH 16 Rev 6/95** 

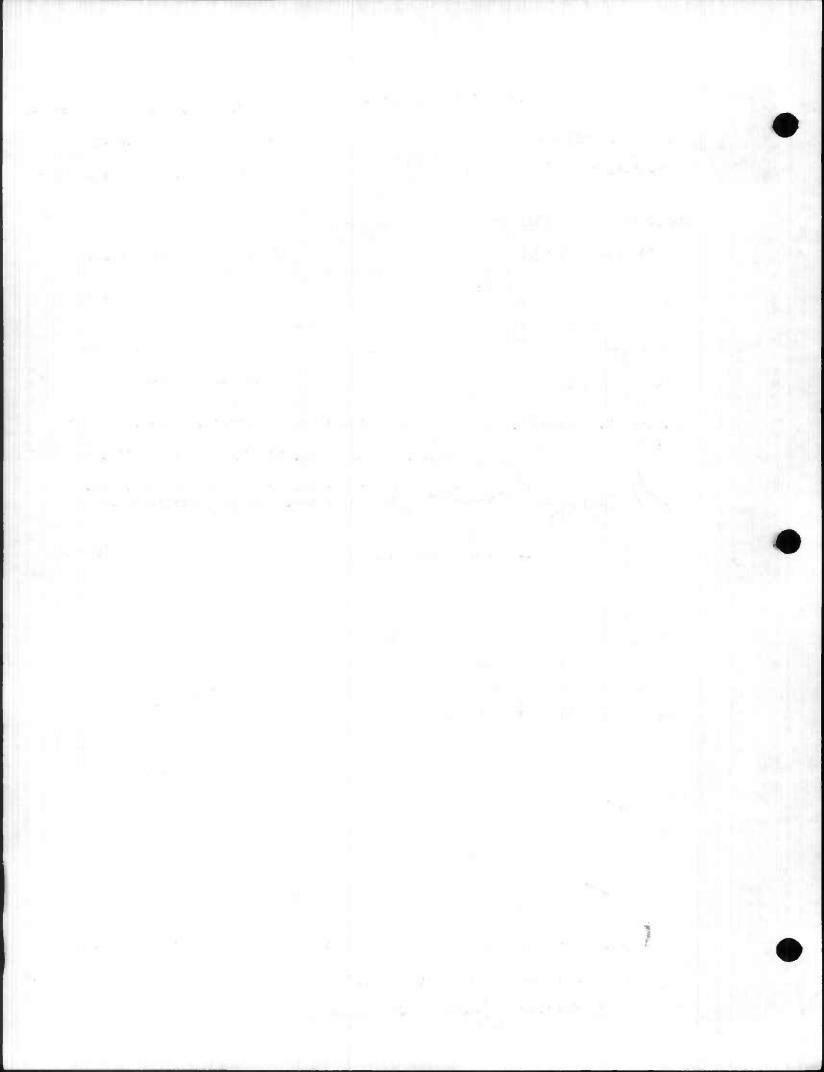


State of Maryland / Department of Health and Mental Hygiene 99 21027

						Cer	tificate o	f Death		Reg. No.	2 2	E . 7	061		
	Physic		Decedent's Name (First, Middle, Last	EDWARD I	LEVERE	SAUE	RWALD		2. Date of Do Month July		Year		ne of Death		
٨	/Medi Exami:		4a. Fecility Name (If not institution, give	street and number)				4b. City, Town, or			nty of Death		4:00 AM		
1	Exami		3110 Greenhill R	oad				Edgeme:	re	Ва	ltimo	re			
Ī	Funeral		5. Social Security Number 6. S 176-01-5408	KIM 2 TE	e (In yrs. last t	oirthday) Yrs.	If Under 1 Yes Months Dey	ar If Under 24 Hrs.	8. Date of Bi (Month, D	rth ay, Year)	9. Birth	nplace (St.	ate or Foreign		
	Director		Usuel Residence of Decedent		38	- 1			April	21,191	1 Pe	nnsy	lvania		
	show	L	10a. Stata 10b. County		10c. City, To	wn or Lo	cation						de City Limits		
	Sa-f	cto	-	altimore			Edgemer	e				10	Yes 212 No		
	1 2 2 E	Director	10e. Street and Number				10f. Zip Code	•		10g. Citizen	of What Cou	intry?			
	23a		3110 Greenhill	Road				2123			ed Sta	ates			
020	be filed within 72 hours after death with the Maryland that Hygiene. Id other than "natural", or items 23s or 28s-f show event, the Medical Examinat must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent   Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			Vas Decedent of Yes, specify Cu	f Hispanlc Origin? (S aban, Mexican, Puert o <i>Specify:</i>	pecify Yes or No o Ricen, etc.)	0- 14. F E Spe	Race - Ameri Black, White cify: W.				
5-0	72 ho	te d	15. Decedant's Ed (Specify only highest gra-	ucetion	16	a. Deced	ent's Usual Occ	upation e during most of wor	tina	16b. Kind of	f Businass/Ir	ndustry			
21215-0020	within 7 ene. than "r	Completed	Elamantary/Secondary (0-12) 10 Years	Collaga (1-4or 5	i+)	Iifa. D	npenter	red)	king	Con	struc	tion			
D	al Hygie other	Ü	17. Father's Name (First, Middla, Last)					18. Mother's Nan	ne (First, Middle	, Maiden Sum	ama)				
lan	d be ental c ev	To Be	Irwin Sauerwald						Ida Mae						
Maryland	should be and Mental I was marked of umatic even	-	19a. Informant's Name/Relationship (7	ype, Print)	19	b. Mailin	a Address (Stre	et and Number or Ru	ıral Route Numb	er. City or Tox	Town, State, Zip Coda)				
Baltimore, Ma	nd 2 lith a 27 is r trai		Mr. Paul M. Sauer	wald/Son		442	Westfie	ld Road	Dundalk	. Marvl	and	2122	2		
	s 1 a f Hea tem othe		20a. Method of Disposition	aza, boii	20b. Place	of Dispos	sition (Name of		Date	20c. Locatio					
	age ent o nt: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			-	f Faith	Cem. 7/3	0/1999	Ross	ssville, Maryland				
Salti	permit. Pages 1 and 2 should b Depertment of Health and Ments Important: if Item 27 Is marked any Injury or other traumatic e once.		1. Signature of Marai Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc.												
ш	00 E 6 0		1 sean	Kee	<i>&gt;</i>			e Ave. D				1222			
П			23a. Part1. Enter the displace or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failth. List only the cause on each line.  Approximatinterval Bet Onset end Conset e												
	Physician /Medical		Immediata Cause That disease or condition Gastic Cauces												
	Examiner		disease or condition resulting in death)									QM	Ω2 <sup>′</sup>		
		Je.		Due to (or as a consaquance of):											
	outed nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate ceuss. Enter Underlying												
o,	an ar	Ä													
68760,	ate be	edical	Cause (Disease or Injury that initiated avants resulting in deeth) Last Due to (or es e consequence of):												
¥ 66	eath certificete be executed attending physician and I for use es the buriel-transit	Med	Tooling in dooling East								-				
Box	death ce			0											
0	0 0 0	/sic	Part II. Other significant conditions of	ntributing to death bu	ut not resulting	in tha un	darlying ceuse	given In Part I.	23b. Dld	tobacco use	contribute t	to the car	use of death?		
<u>a</u>	that the death	by Physician	Valvular He	ourt Di	Seas	ie			1 🗆	Yes 2 1	3 □ Pro	bably	4 Unknown		
ds,	requires t								24a, Was	an autopsy	24b. V	Vara autor	psy findings		
Vital Record	v require been si should	Completed								ormed?	6/	vallable prompletion	rior to		
Re	The law ate has b	ш							40			f death?	-0.11		
ā			25. Was cese rafarred to medical						1 🗆		1	☐ Yes	2 No		
		o Be	examiner?	Hospital:			- C	26. Place of Das other:		-					
of	두 분들	-	27. Mannar of Death	1 ☐ Inpatie		Time of	3LI DOA	4 LI Nursing H	ome 5 D nes 28d. Describe		4-1/-	ify)			
on	tending Ph leath. lor: After thi the funeral	tior	1 Natural 5 Panding 2 Accident invastigation	(Month, Day	Year)	Injury	28c. In W	ork? □Yes 2□No		non injury out					
Division of	dea ctor: y the	fica	3 ☐ Sulcide 6 ☐ Could not be		ury - At home.	farm, stre			28f. Location	Street and Nu	mber or Rur	ral Route	Number.		
Š	Direction of the direct	Certification:	4 Homicide	building, afo	(Specify)		,,,		City or To	wn, State)					
	spita hours neral y fille		29a. Certifiar 1 Certifying Phy	alcian: To the best of	f my knowledg	a, daath	occurred at the	time, date and place	, and due to tha	cause(s) and	manner as r	stated.			
	To the Hospital or Attending I within 24 hours effer death. To the Funeral Director: Affer completely filled in by the fune.	edical	(Check only 2 Medical Exam	Inar: On the basis of and manner sta	examination a	nd/or inv	estigation, in my	opinion, daath occu	rred at the time,	data and place	e, and due t	to tha cau	se(s)		
	To the To the Comp	Σ	29b. Signature and titla of certifier	1.5				29c. License number 29d. Data signe					ar)		
			Kornerte D	and for			D	39660		July	28.	1991	7		
		ŀ	30. Name and address of parson who c	ompleted causa of da	aath (Item 23a)	) (Type, F	Print)			- 4.1	- 1	v	1		
			Robert C. Duct	Tr. mr	751	و) و	North	1 Point	Rd. Bo	ilfimo	re W	10 2	1219		
	Sta	te	31. Date filed (Month, Day, Year)	32. Reğiştra	r's Signatura		-	- ,							

Registrar

DHMH 16 Rav 6/95



State of Maryland / Department of Health and Mental Hygiene ]

Amended Item#24a per∀erbal Md G773 7/30/99 EW Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** Month Year ROSEHARY IFFANY 11:17 AM 1999 13 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth **Examiner** 4c. County of Death Manor care Towson TOWSON 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 6. Sex If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Cleveland, OH **Funeral** 1□M AGF Days 106-32-9623 Months Yrs. Director Usuel Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location rati, or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 1 Tes 2 940 Baltimore White Hall, Director MD 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? Zelda Court USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 11. Merital Status Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after mont of Health and Mentale Hygiene.

III: If item 27 is marked other than "natural; or ite wy or other traumatic event, fire Modes Examine. 1 Never Married 2 Married 1 ☐ Yes 20 No Baltimore, Maryland 21215-0020 1 ☐ Yes 2 D No Specify: Specify: (A) Completed by 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) school teacher Elementary School 12 4 yrs 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Sumame) Be wallach Douglas Elizabeth Patee 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) white Hall, MD Robert 9 zelda Ct. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete Department of I-Important: If its any injury or or once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/13/99 TOWSON, MI 4 Donation 5 ☐ Other (Specify) MD State Anatomy Bd. 21. Signature of Funeral Service Licensee 22. Name end Address of Facility B. Van Sant State Anatomy Board, 655 W. Baltimore Street Joseph Baltimore, MD 21201
cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the cause on each line. Approximate Interval Between Physician Onset and Death PNEUHONIA immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): **burla-fre** Division of Vital Records, P.O. Box 68760, 8 that initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 ⊕4mknown 1 ☐ Yes 2 ☐ No EMENT/A þ Completed 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? Thetaw this certificate has 1 Ves 2 € No 1 Yes 2 No Ini or Attending Physician: The after death.

In Director: After this certificate of in by the funeral director, pa Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1□Yes 25046 Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manney of Death 28a. Date of Injury (Month) Day Year) 28h. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 DiNatural 5 Pending 1 Yes 220Mo 2 ☐ Accident investigation 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) A / C 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D completely filed it 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, dete and pieca, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Yeer) tur D34952 30. Nama and address of person who complated causa of death (Itam 23a) (Type, Print) 7600 OSLER DRIVE TOWSON MARYLAND 21204 EVELLYES H.D JOHN I. 1999<sup>32. Registrar's Signatura</sup> State

Registrar

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State of Maryland / Department of Health and Mental Hygiene 🔾 🔾 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician Agnes M. Tehan July 1999 28 6:55 A.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5845 Richardson Mews Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) Days 1 M 20 F Months 059 01 7768 87 April 27, 1912 New York Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d, Inside City Limits Maryland Baltimore 1☐ Yes 2X No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5845 Richardson Mews 21227 U.S. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: ģ 3 to Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk State of Maryland 10th 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumame) James Bannon Anna Farrell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Ann Tehan Daughter 5845 Richardson Mews Baltimore, Maryland 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 15 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, Maryland Glen Haven Memorial Park 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gonce Funeral Home P.A. namerouski 4001 Ritchie Highway Baltimore, Md. 21225 nua 23d. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Unit only one cause on each line. Approximata Intarval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Colon Physician/Medical Examiner Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Leukemis 1 Yes 2000 3 Probably 4 Unknown pho cy tic þ 24b. Ware autopsy findings available prior to completion of causa of death? Be Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yas 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) 1 Yes 2 No Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number d address of person who completed ceuse of death (Item 23a) (Type, Print) 5411 Old Frederick Rd Boto MD 21228

**DHMH 16 Rev 6/95** 

State Registrar

completely

**Funeral** 

Director

show

28a-f

must be n

Hygiene. ther than "natural", or Itan int, the Medical Examinar.

Peges 1 and 2 should be fill ment of Health and Mental Hy ant; if Item 27 is marked oth lury or other traumatic event

Department of Important: If any injury or

**Physician** 

/Medical

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page 2 should

After this certificate has

or Attending Physicien: ours efter deeth.

erel Director: After this certification by the funeral director.

To the Hospital within 24 hours

The lew requires that the death certificate be executed

Box 68760.

P.0.

of Vital Records.

Division

Examiner

filed within 72 hours after

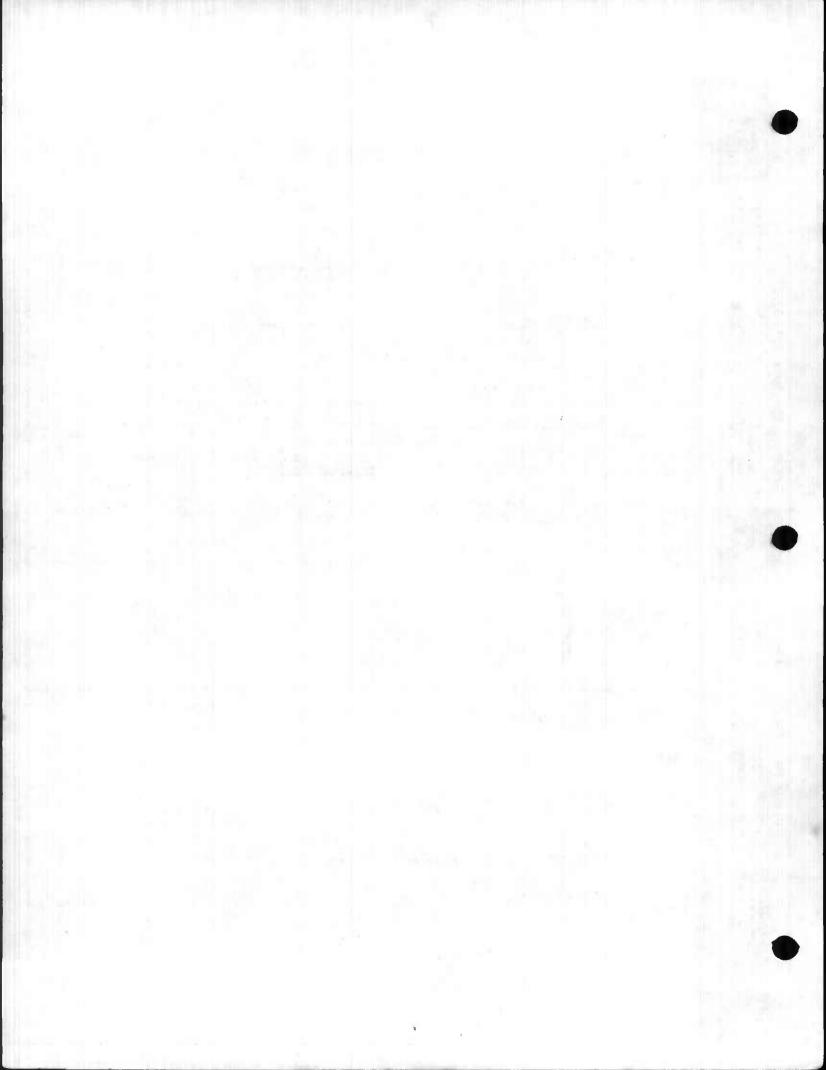
Saltimore, Maryland 21215-0020

the Maryland

AN 31. Date filed (Month, Day, Year)

REISINGER ELL MID 32. Registrar's Signature

**ORIGINAL** 



attending physicien end for use es the buriel-transit The law requires that the death certificate be executed signed by the aid be deteched for peeu is certificete hes t director, page 2 s Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice etely filled in by the funeral director, i

**Physician** 

/Medical

Examiner

Director

Funeral

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Certification:

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1 Natural

2 Accident 3 Suicide

4 - Homicide

29a, Certifier

**Funeral** 

**Director** 

Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland

end Mentel

permit. Peges 1 and 2: Department of Health et Important: if item 27 is any injury or other traugates.

**Physician** /Medical

Examiner

altimore, Maryland 21215-0020

7 is marked other than "naturel", or frems 23s or 28s-f ehow traumatic event, the Medical Examiner must be notified at

P.O. Box 68760. Division of Vital Records.

To the Hospital or within 24 hours aft To the Funeral Dis completely filled in

State Registrar

Moges 31. Date filed (Month, Day, Year) JUL 3 0 1999

29b. Signeture end title of cartifier

5 Panding investigation

6 Could not be determined

Gebre manan

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

32. Registrar's Signature

4660 W. lkeus

Iniun

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes

1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, and due to the cause(s) and manner as stated.

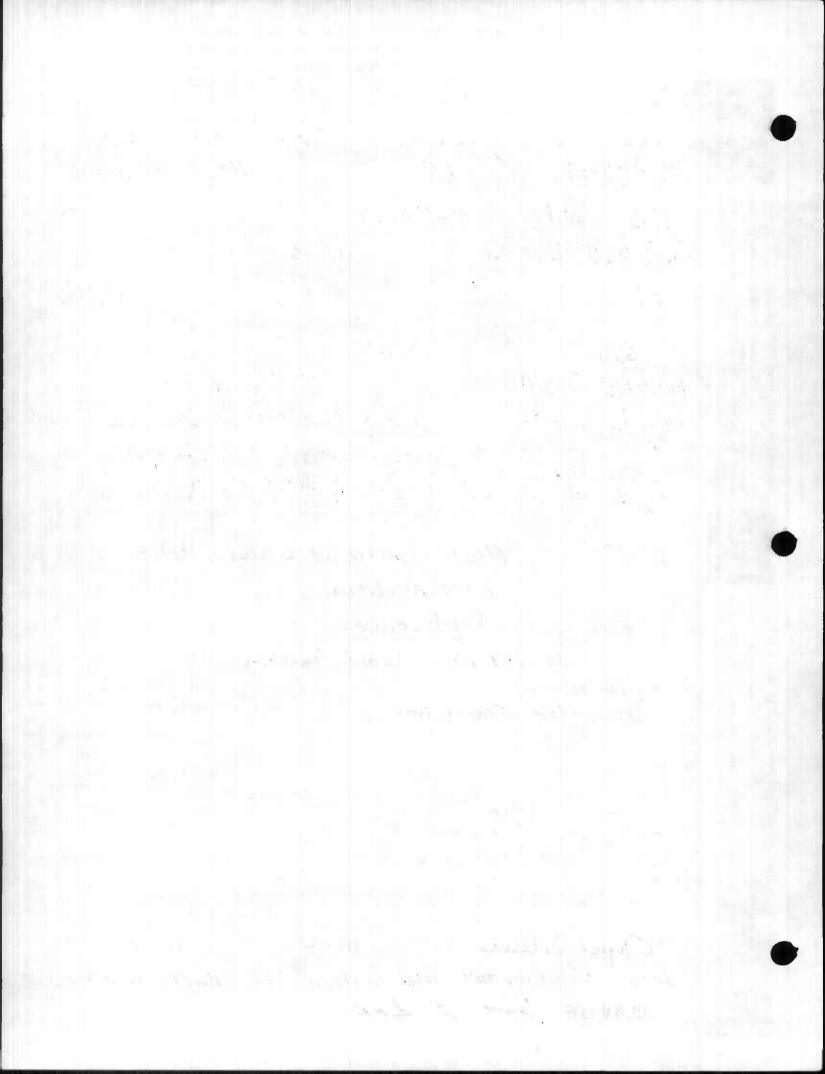
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, dete end place, end due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

**DHMH 16 Ray 6/95** 



E	DWARD C	AR	State of Maryland / Department of Health and Mer  Certificate of Death	ntal Hygie	99 7	14031
	Dhualai		1. Decedent'a Neme (First, Middle, Last)	. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Edoudie de la	JULY 26	1999	0250 AM
	Examin	er	4e Facility Name (If not institution, give street and number) 4b. City, Town, or Locat JOHNS HOPKINS HOSPITAL BALTIMORE	tion of Death	4c. County of Death	11
_				Date of Birth	/V /	lace (State or Foreign,
	Funeral Director		218-88-7382 11XM 20F 33 Yrs. Months Days Hours Min.	Month, Day, Yo	1966 NO	try)
	b		Usuel Residence of Decedent	in a	1001119	7 700100
	death with the Meryland rms 23a or 28a-f ehow rmst be notfried at	×	10a. Stete 10b. County 10c. City, Town or Location		1	0d. triside City Limits  1 ☑ Yes 2 ☐ No
	788 N	Funeral Director	10e. Street and Number 10f. Zip Code	100	Citizen of What Cour	/ \
	Sa or	O	821 Bradford St 21205	log	11 < F	1
	death death	nera	11. Menitel Status  12. Wes Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specifit Yes, specify Cuban, Mexican, Puerto Ric	y Yes or No-	14. Race - Americ	
0	or he		1 Never Merried 2 Merried 1 Never 1 No	an, etc.)	Black, White,	etc.
21215-0020	be filed within 72 hours after tal Hygiene. d other than "netural", or ite event, the Medical Exercity	d by	3 Widowed 4 Divorced Year or Dates:	1	Affrican	America
5	in 72	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired)	16	o. Kind of Business/In	dustry
212	filed with Hygiene. other than	E O	Elementery/Secondery (0-12) College (1-4or 5+)		Private	(0.
	al Hyy	Be C	17. Father's Neme (First, Middle, Last)  18. Mother's Name (F	First, Middle, Mai	den Sumeme)	
yla	should be nd Mental marked o	2	Selester Valentine Mart	ha	Davis	
Maryland	32 sh h and 7 is m treum		19a, Informent's Neme/Relationship (Type, Print) (Wite) 19b. Meiling Address (Street and Number or Rural R	Route Number, C	ity or Town, Stete, Zic	Code)
	1 and Health em 27		20e. Method of Disposition   20b. Place of Disposition (Name of	Date/ 200	c. Location - City or To	own, Stete
OE	Pages nent of int: If its ary or o		1 Burial 2 Cremetion 3 Removel from Stete 4 Donetion 5 Other (Specify)	5/99 F	Brita	Md
Baltimore,	2 E E F		21. Signaffure of Funeral Service Licenses 22. Name and Address of Fecility	1., 1	111	100.
m	Depa Impo		Meph L. Kuss Joseph North A	- rune	eral Hor	ne 313-16
			23a. Part. Enter the disease, or complice lors that caused the death. Do not enter the mode of dying, such as cardiac or resports, or heart fallure. List only one cause on each line.	espiratory errest		Approximele Intervel Between
	Physician /Medical		Immediate Cause (Final	9	Rail	Onset and Deeth
*	Examiner		disease or condition resulting in death)  a.   Guilla Valla	10	Dae	
	D #	ner	Due to (or as a consequence of):			
	cate be executed physician and the buriel-transit	dical Examiner	Sequentially list conditions,  Due to (or as a consequence of):			
8760,	ician d	a E	if any, leading to immediate cause. Enter Indentying Cause (Disease or Injury		!	
687	phys s the	•	that initiated events resulting in death) Last  Due to (or as a consequence of):			
Вох	law requires that the death certificate be executed es been signed by the attending physician and a 2 should be detached for use as the buriel-transit	Physician/M	d			
B	death	sicie	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. Did tobe	cco use contribute to	the cause of death?
P.O.	d by the	Phy		1 Yes	20 No 3□Pro	bably 4 Unknown
ds,	signe d be d	Completed by		24a. Was an a	24h W	ere autopsy findings
Records,	peen shoul	lete		performe	d? av	ailable prior to mpletion of cause death?
Re	The law ate hes page 2	шо		1 Z Yes		PYes 2□ No
Division of Vital	diffical	Bec	25. Was case referred to medical 26. Place of Death (C			
>	Attending Physician: r death. sector: After this certific by the funeral director,	To			e 8 Other (Specif	y)
NO CO	Ing P	inol.	1 Natural 5 Pending (Mpnth, Day Year) Injury Work?	d. Describe how	injury occurred	1.
200	or Attendi after death Director: A I in by the f	licat	2 Accident investigation   1   Yes 2   No   1   Yes 2   No   2   Suicide   4   Suicide   28e. Place of Injury - At home, ferm, street, fectory, office   28f.	Location (Student	et and Number or Run	Il Route Number.
2	after after din b	Certification:	4 MHomicide determined 288. Place of Injury - At nome, term, street, tectory, office building, etc. (specify) Found 821 N. Bradfor	City or Town, S	Ralt.	more Md
	pepits hours iners by fille		29a. Certifier 1□ Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and	due to the caus	e(s) and manner as s	tated.
	To the Hopital or Attending Physician: The is within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page.	Aedicai	one) end manner stated.			
	o T V D	2	29b. Signeture and this or curtifier		Date signed (Month,	
		-	y fulance, (V(.)). O.C.M.E		JULY 27, 1	999
			30 Name and abdress of person who completed cause of death (Item 23a) (Type, Print)  VESTAVET 111 Penn Street, Baltimore	e. Marvl	and 21201	
	Sta	e	31. Date ided (Month Day, Year) 32. Registrar's Signature	,		
	Registra		JUL 3 0 1999 J. Sparks.			

State Registrar

DHMH 16 Rev 6/95

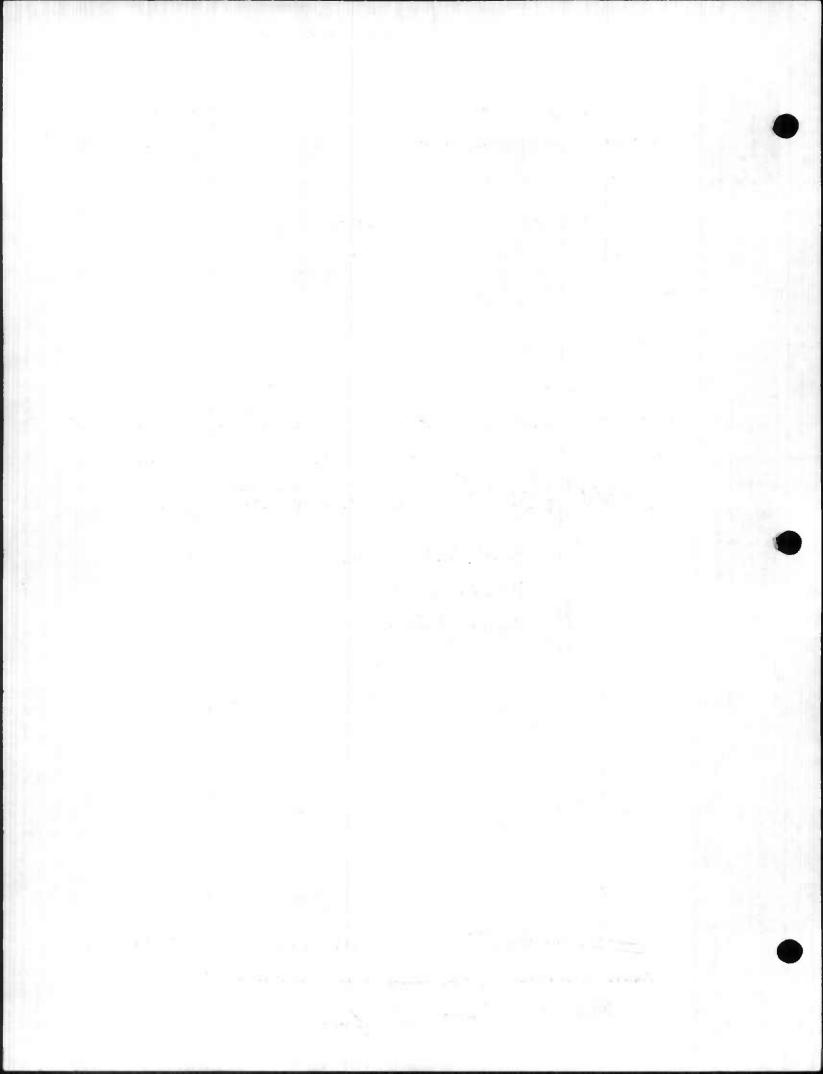


State of Maryland / Department of Health and Mental Hygiene

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						Cer	tificate d	of L	Death			Reg. No.			
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	Physic		Caro1	yn C. Wie	PC70r4	a k					July	28, 1	Year 999	6.	32 AM
	/Medi Exami		4e. Facility Name (If not institution, gr	ve street end number)	CCZOIC			41	b. City, To	wn, or Lo	ocation of Deetl	-	ty of Death	0,	J4 AF
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-	C				e (In yrs. lest		If Under 1 Ye		If Under		R Date of Bir	th	Balti		
	Funeral Director			4 D M OFF	85	Yrs.		eys	Hours	Min.	OCT 22	y, Year)	Cour	ntry)	te or Foreign
	Director		Usuel Residence of Decedent		0)						001 22	, 1913	UNK	•	
	and		10a. State 10b. County		10c. City, To	wn or Loc	cation						1	Od. Inside	e City Limits
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	the the	Director	Maryland Baltir	nore			Cato		V1I.	Le		10. 011.			
	E & E											10g. Citizen of Whet t			
	72 hours efter death with the Maryland natural", or Items 23a or 28a-f show ited Examiner man be notified at	Funeral	6348 Frederic				212						USA		
	or de	Š	11. Marital Status	12. Wes Decedent I Armed Forces?		13. W	Vas Decedent Yes, specify (	of His Cubar	spenic Ori n, Mexicei	gln? (Sp 1, Puerto	ecify Yes or No Rican, etc.)	- 14. Re	ece - Americ eck, White,		٦,
3	of off	T Y	1 Never Married 2 Married	1 Yes 2 X	No		☐Yes 212						ity: Wh:		
	in in	d by	3 Widowed 4 Divorced	Year or Dates:								Орос	.,. WILL		
41410-040	d within 72 hours piene. r then "neturei", tre Med cei Exe	Completed	15. Decedent's E (Specify only highest gr	ducetion rede completed)	16	Give k	ent's Usuai Oc	ccupa	tion	t of work	ina	16b. Kind of	Business/In	dustry	
1	filed within Hygiene. ther than out, tre Me	ď	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life. D	O NOT use re	etired)			9				
	w po pa	20		2		Teac	her				Education				
mai yiania	0 = 0 >	Be	17. Fether's Name (First, Middle, Les	t)					18. Mother's Name (First, Middle, Meiden Surneme)						
!		To	George A. Wied	zorek					Cor	inn	e Giad	comini			
	S DEE	-	19a. Informent's Neme/Reletionship	(Type, Print)	11	9b. Mailing	g Address (Str	reet e	nd Numb	er or Aur	al Route Numb	r, City or Town, Stete, Zip Code)			11 305
	tra er		Corrine Wieczo	rek/Niec	e 1	000	E. Jo	pp	a Ro	ad.	Apt.	103 т	OWSOI	a. Mī	2128
,	of Healt		20a. Method of Disposition		20b. Place	of Dispos	ition (Neme o	of		,	Dete	20c. Location			
			1 ⊠ Burial 2 □ Cremation 3 [			-	etory or other	-		lo	12/00	Woodlawn MD			
	rtan rtan		4 Donetion 5 Dother (Specify) Woodlawn Cemetery 8/2/99 Woodlawn, 21. Signature of Funeral Service Licenses 22. Name and Address of Facility												
	permit. Page Department of Important: if any injury of once.		21. Signature of Funeral Service Lice	1000	/						Home,	РΔ			
	70 = 6 Q		Edward A.	regerchi	k	30	1 Fre	de	rick	Ro	ad Cat	onsvi	11e.	MD	21228
			23e. Pert1. Enter the disease, or coordinaters that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heert failure. List only one ceuse on each line.												
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	/Medical		Immediate Ceuse (Final	9.2.A.	1 T	)	200						I		
	Examiner		disease or condition resulting in deeth)		-			*		_					
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	certi ding	3		d											
	etter for u	Physician													
	res thet the deeth signed by the etter be detached for it	ysi	Part II. Other significant conditions	contributing to death bu	ut not resulting	in the un	derfying ceuse	e give	n in Pert I		23b. Did	lobacco uaa c	ontribute to	the cau	se of death?
	het t										1 🗆	Yes 2□No	3 Pro	bably 4	Unknow
	The law requires thet ite hes been signed b page 2 should be dete	by													
	v require been si should i	ted										en eutopsy rmed?	ev	alleble pri	
	hes be	pie												mpletion deeth?	of ceuse
	The I	Completed									10	res 2 No	1.	☐ Yes :	2□ No
		(D)	25. Was cese referred to medicel						26 Place	of Dogs		-34			
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	or Attending efter death. Director: After I in by the fune	Certification:	4 ☐ Homicide determined	28e. Place of Injubuilding, etc.		tam, stre	et, factory, off	ICO			28f. Location (3 City or Tol		iber or Hurs	House A	vum <i>ber</i> ,
	rai e														
	To the Hospital or Attending is within 24 hours efter death. To the Funeral Director: After completely filled in by the funer	edical	(Uneck only 2 Medicat Exa	nyalcian: To the best of miner: On the basis of	exemination a	ge, deeth	occurred et the	ne time	e, dete en Inion, dee	d place, th occurr	end due to the ed et the time.	ceuse(s) end n	nenner es s	tated. the ceus	se(s)
	within 2 To the	Med	one)	and manner sta	ited.										
	0 1 × 0	~	29b. Signature end title of certifier	1					number			29d. Date sign			r)
				or sal	)		D	13	36	6		1/2	18/3	17.	
			30. Neme end eddress of person who	completed ceuse of de	eath (Item 23e	) (Type, P	rint)								
			Adman M. Son		S N. P			(	Al.	KM.	21228				
	Sta	te	31. Date filed (Month, Day, Yeer)		er's Signeture										
	Registr		JUL30	1999	una	6	1								

DHMH 16 Rav 6/95



		Decedent'a Name (First, Middle, La	st)		Certifica	te of l	Death	2. Dete of De	Reg. No.	9	2 4 0 3 3 3. Time of Death	
Physicia /Medic		Harry	W	olf				Month	Dey	1999	11:20 PM	
Examin Funeral	er	4e Fscility Name (If not institution, given the first of	ere S	(In yrs. last t	, , ,	er 1 Yeer	Beth If Under 24 Hrs. Hours Min.	8. Dete of Bird (Month, De	Mon	9. Birthp	lece (State or Foreign	
Director		540-07-8253 Usuel Residence of Decedent  10e. Stete 10b. County		10c City To	wn or Location			Februar	26 191		egon  Od. Inside City Limits	
O efter death with the Manylar or items 23a or 28a-f show refree must be notified as	tor	Maryland Howar	_		mbia						1 ☐ Yes 2€ No	
ith the	Funeral Director	10e. Street and Number			10f. Z	p Code			10g. Citizen of V	Vhat Cour	itry?	
s 23e	eral	7218 Dockside Lan	e 12. Was Decedent Ex	ver in U.S.	13 Was Dec	2104.		pecify Yes or No	U.S.A.  14. Rece - American Indien,			
72 hours effer death with the Maryland 72 hours effer death with the Maryland natural; or items 23a or 28a-f show steel Examiner must be notified at	by	1 Never Married 2 Merried 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates:		If Yes, sp		ispanic Origin? (S on, Mexican, Puert Specify:	o Rican, etc.)	Bled	Bleck, White, etc.  Specify: white		
	Completed	15. Decedant'a E (Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5+		life. DO NOT	use retired	ation during most of wor f)	king		of Business/Induatry		
e filed withing the Mygiene.	CO	17. Father's Nama (First, Middle, Last	5+		Physic	ist	18. Mothar's Nan	ne (First, Middle,	U.S. G		nment	
Maryland d 2 should be file th and Mental Hy 7 Is marked oth traumatic event	ro Be	Jacob Wolf					Johanna	a August	a Rensc	schke		
2 sho and hals ma		19a. Informant's Name/Raiationship (								Town, Stete, Zip Coda)		
more, Pages 1 an ent of Heel nt: If itsm 2 ry or other		R. Peter Wolf/son  7001 Barkwater Ct., Bethesda, MD 20817-4  20e. Mathod of Disposition  1										
Balting pemit. Pa Department Important any Injury once.		21. Signature of Funerel Service Lice Ronald S		rector		Ana	tomy Boar	rd, 655	W. Balt	imore	Street	
Physician /Medical Examiner	Jer	Part1. Enter the disasse, of composition of hard failure. List only immediate Causa (Final disease or condition resulting in deeth)	a. G	lish	lzstv n	12	g, such as cardiac	c or respiratory e	rrest,		Approximate Interval Batween Onset and Deeth	
68760, fficate be executed 3 physicien and as the buriel-transit	edical Examiner	b. Due to (or es e consequenca of): if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events  Due to (or as e consequence of):										
Centifi ding		resulting in death) Lest	d									
P.O. hat the did the d	Physician/M	Part II. Other significant conditions of	ontributing to death but	not resulting	In the underlying	cause giv	en in Pert f.	23b. Did			the cause of death? bably 4 Unknown	
tw requires s been sign 2 should be	Completed by							24e. Was	en eutopsy ormed?	av	ere autopay findings ailable prior to mpletion of cause daath?	
The law ate has page 2	Com							10	Yes 2 No	1(	Yes 2 No	
Physician: The Physician: The This certificate ral director, pag	Be	25. Was casa rafarrad to medical examiner?	Hospital:			Oth		ath (Chack only				
Jn OT Offing Phys	ation: To	1 Yes 2 No  27. Manner of Death 1 Naturei 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Dey		Outpatient 3 C D. Time of Injury	28c. Injur Wor	4 Nursing F	fome 5 ☐ Rasi 28d. Describe	dence 6 LIOth how injury occur		ý)	
2 9 4 9 E	edical Certification:	3 Suicide 6 Could not be determined	28e. Placa of Injur building, etc.		farm, street, facto	ry, office		28f. Location ( City or To		er or Rur	al Route Number,	
Hospital 24 hours a Funeral stely filled	dical		ysician: To the best of niner: On the basis of e and mannar state	examinetion e								
within within Comple	Me	29b. Signeture end title of certifier	and marinar state	anal.	2	9c. Licens	e number		29d. Date signe			
0.		SHENO	& MO	oth (lane as	(Time Britt)	)5	0776		1	6/90		
W			IERSLEY	MO	4801 Du	rsen	Hell Dr.v	i Svite 7	OIB B	liet	CIM MO	
Sta Registra		31. Date filed (Month, Day, Year)  JUI 3 0 1999	32. Registrar	's Signature	100							

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#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

ADELE WATTS

Stat	e of	Maryla	and /	Dep	artme	nt of	Hea	lth and	Mental	Hygiene
				-						

Physi /Mec

Exam

Funera Directo

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; or items 23a or 28e4 show any injury or other traumette event, the Medical Examiner mast be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examine To the Hospital or Attending Physician: The law requires that the death certificate be associated within 42 hours affect death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlat-transit

			Cei	rtificate	e of	Death			Reg. No.	99	26	031
1. Decedent's Neme (First, Middle	, Last)							2. Date of De Month	eath Day	Year	3. Tin	ne of Deat
Adele LaFever	Watts							JULY		1999	7:1	8P.M.
la Facility Neme (If not institution	, give street and n	umber)					wn, or Lo	cation of Deat	-	nty of Deat		01 111
5713 EDMONDSON	AVE					CAT	ONSV	ILLE	BALT	IMORE	Ξ	
5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under		If Under		6. Date of Bir	th Vees	9. Birt	hplace (St	ete or For
216-32-7428	1□M 2只F	95	Yrs.	Months	Days	Hours	Min.	Sept 3	, Yar 1903	Ma	hplace (St untry) rylai	nd
Usuel Residence of Decedent		1										
MD Balt	imore		ly, Town or Lo atonsvi									de City Lin
Daic	Into I C	06	10113 1	.110							10	Yes 2
10e. Street and Number				10f. Zip	Code	2100	10		10g. Citizen o	/What Co	untry?	
5713 Edmondson	n Avenue					2122	.0			0.5.	Α.	
11. Meritel Status		cedent Ever in U	,S. 13. 1	Was Deced	lent of I	lispanic Ori	gin? (Sp	ecify Yes or No		ace - Ame		in,
1 Never Married 2 Merri	ed 1 Yes	2 No					, Puerto	rucan, etc.)	Rican, etc.) Black, V			
3 ☐Widowed 4 ☐ Divorced	If Yes, G Year or	ive Dates:		1□ Yes 2	2L3 No	Specify:			Spec	ily: Whi	ite	
15. Decedent	a Education		16a. Dece	dent's Usua	l Occup	ation			16b. Kind of	Business/	Industry	
(Specify only highes	1	(1-4or 5+)	life. I	kind of wor DO NOT us	e retire	d)		ing				
Elementary/Secondary (0-12)	Compage	(1-401 34)	Groce	ery Pı	ropr	rietor			Funk '	s Mai	rket	
17. Father's Neme (First, Middle, I	ast)							e (First, Middle		ame)		
William Funk						Isab	elle	Hoope	r			
19a. Informent's Name/Reletionsh	nip (Type, Print)	-	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zig								Zip Code)	
Edgar Thomas Wh		Sr.										
20e. Method of Disposition		20b. I	Place of Dispo	sition (Nam								te
1 ☐ Buriel 2 ☐ Cremetion	n State	_	y, crematory or other place)									
4 ☐ Donetion 5 ☐ Other (Sc	January Marge Commercial 1700755 Editimore.											
21. Signature of Funeral Service	Scientife /	) )										
& BOY ON Y	166		10	030 E	dmor	idson	Aven	ue, Ca	tonsvil	le, l	MD 21	228
Sequentially list conditions, if any, leading to immediate	<b>7</b> b		or as a conseq							]		
cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (c	r aa a conseq	uence of):			<del> </del>					
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Dort II. Other elemificant condition	no nontribution to	double had not one	undate or to about a	adad in a sa		and in Part I		non Did	Ashanas una		An Abn an	una al da
Pert II. Other algnificant condition	ns contributing to e	death but not res	uiting in the u	ndenying ca	ause gn	/en in Pert I			tobacco uss			
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								240 141-	en autono	24h 1	Were auto	nsy findin
								perfe	an autopsy omed?	1	availeble p	prior to
								ınspe	ection		of death?	
								10	Yes ANO		1 🗆 Yes	2 No
25. Wes case referred to medicat examiner?						26. Place	of Deat	h (Check only	one)			
examiner? 1 X Yes 2 □ No	Hospital:	Inpatient 2	ER/Outpatier	nt 3□ DO	A Ott	ner: 4□ Nu	rsing Ho	me 5% Resi	idence 6 🗆 0	ther (Spe	cify)	
27. Manner of Death  1 ☑Natural 5 ☐ Pending 2 ☐ Accident investig	28a. Date (Mo		28b. Time of Injury	M 2	8c. Inju			28d. Describe				
3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Plac	se of Injury - At h ding, etc. (Speci	ome, ferm, str fy)	reet, factory,	, office			28f. Location ( City or To	Street and Nu wn, State)	mber or Ru	ural Route	Number,
29a. Certifier  only  1 CertifyIn  2 Medical E	Physician: To the locaminer: On the locaminer	e best of my kno basis of examina nner stated.	wiedge, death ition and/or im	occurred a vestigation,	in my c	me, date an opinion, dea	d place, th occurr	end due to the red at the time,	cause(a) and date and place	manner as e, and due	stated. to the car	use(s)
29b. Signatury and title of certifier	1	^		29c.	Licens	e number			29d. Dete sig	ned (Monti	h, Day, Ye	ar)
* 1	1 1	100				a		- 1				
1 pant	whe !	VVV			0.	C.M.E	•		JULY 2	1,199	19	
30 Name and address of person v	vno completed car	ise of death (Iter	n 23a) (Type,	Print)								
J. Laron Locke			ma. 144	111 P	enn	Stre	et,	Baltimo	ore, Ma	rylan	d-21	201-
31. Date filed (Month, Day, Year)		Registrar'a Slovi	2	boux	1,					4		
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	/		. ,									

St Registrar

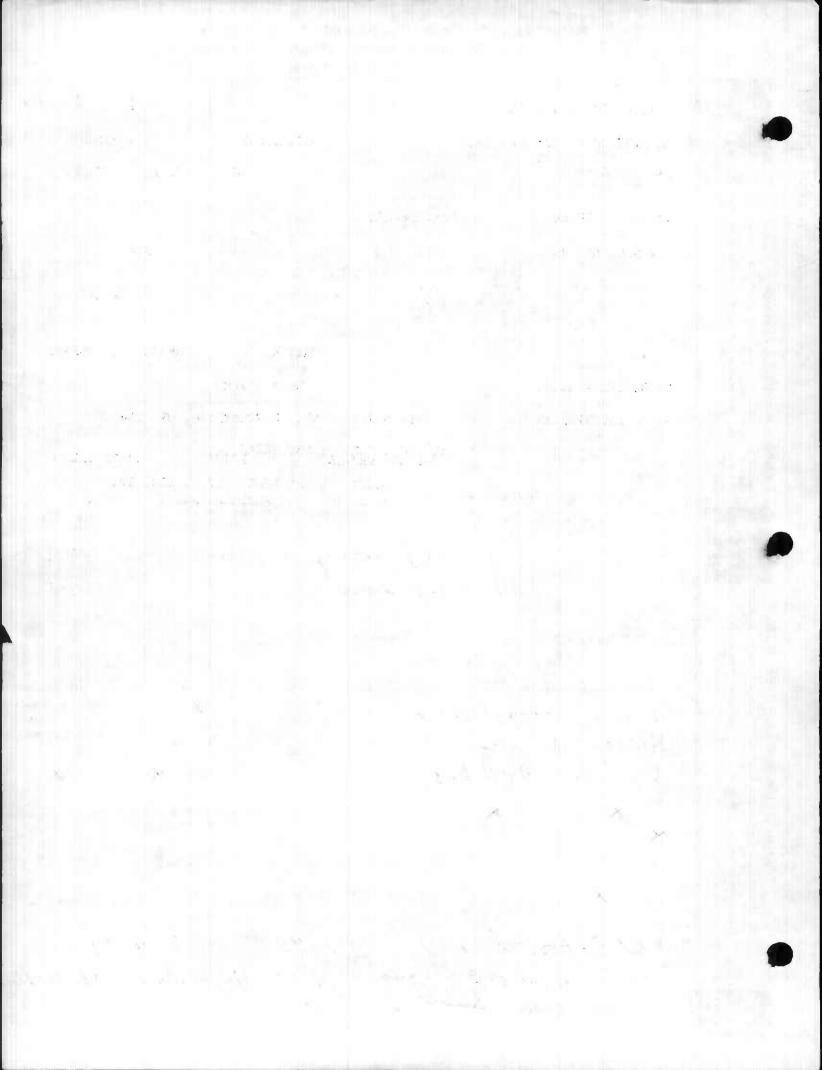
DHMH 16 Ray 6/95

morning to the

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** 2:40 PM HARRY LIONEL ANDREWS /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not Institution, give street and number) 4c. County of Death Examiner HAGERSTOWN WASHINGTON WASHINGTON COUNTY HOSPITAL If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** Deys Min 1X M 2 ☐ F Yrs 81 MARYLAND **Director** JULY 17, 1917 214-09-4493 Usual Residence of Decedent death with the Marylend 10a. Stete 10b. County 10c. City, Town or Location 10d. fnside City Limits r than "naturel", or items 23s or 28s-f shorter Medical Examiner must be notified at 1 Yes 2 No Director MARTINSBURG WV BERKELEY 10f. Zip Code 10a. Citizen of What Country? 10e. Street and Number 497 SCRABBLE ROAD 25401 U.S.A. Funeral 12. Wes Decedent Ever in U,S.
Armed Forces?

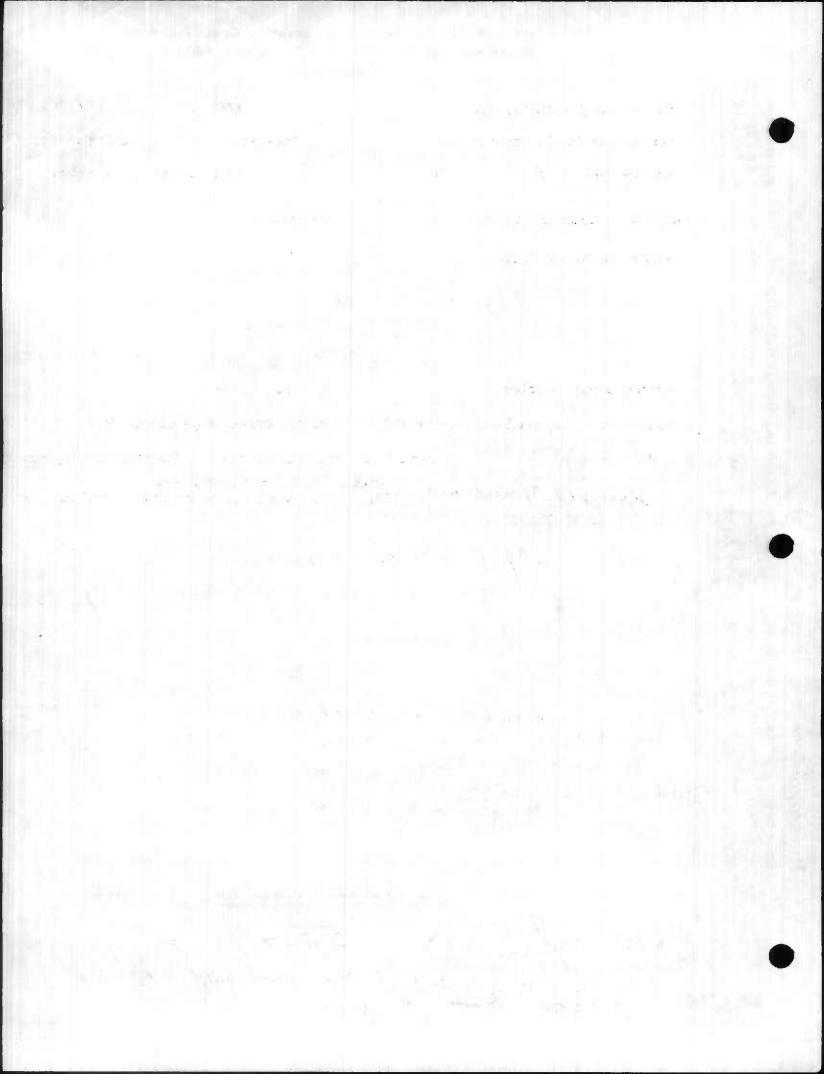
1. Yes 2 No 5/42
Yeer or Detes TO 10/45 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 11. Meritel Stetus Bleck, White, etc. filed within 72 hours efter 1 Never Married Married 1 Yes 2 No altimore, Maryland 21215-0020 Specify. Specify: WHITE by 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) HESSE OIL COMPANY 10 DRIVER .. Pages 1 and 2 should be filed v tment of Health end Mental Hygie tant: If item 27 is marked other t jury or other traumatic event, in 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be MARY BOWERS FREDERICK ANDREWS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) 497 SCRABBLE RD., MARTINSBURG, WV 25401 HILDA ANDREWS/WIFE 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20e. Method of Disposition cometen, cremetory or other place LLING WATERS PRESBYTERIAN CHURCH CEMETERY 1 Buriel 2 □ Cremation 3 □ Removel from Stete permit. Page Department of Important: If any Injury or pace. HEDGESVILLE, WV 4 ☐ Donetion 5 ☐ Other (Specify) 17/99 21. Signeture of Funerel Service Licensee . Neme end Address of Fecility BROWN FUNERAL HOME, 327 W. KING ST. 11. Drown P. O. BOX 821, MARTINSBURG, WV Approximete Intervel Between Onset end Deeth 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Physician /Medical Immediate Cause (Finat disease disease or condition resulting in deeth) **Examiner** Atherosclerous Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of) use Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown ung disease by 24b. Were autopsy findings evalleble prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed disease 1 ☐ Yes 2 No 1 ☐ Yes 2 N.No abetes certificate Division of Vital 25. Wes case referred to medical exeminer? Hospital or Attending Physician: Be 28. Place of Death (Check only one) Other: 4 Nursing Home 5 Residenca 8 Other (Specify) Hospitel: 0 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28e. Dete of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Naturel 2 Accident 5 Pending 1 🗌 Yes 24 hours after death. Funeral Director: Al Investigation 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end place, and due to the ceuse(s) and manner as stated.

2 Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and menner stated. To the Hosp within 24 hou To the Fune completely fi edical 29a. Certifier (Check only one) 29d. Dete signed (Month, Dey, Year) 29b. Signeture and title of cartifier 29c. License number ed cause of deeth (Item 23e) (Type, Print) St., Hagerstown, Md. 21740 31. Date filed (Month, Dey, Year) 32. Registrer's Signature State JUL 1 6 1999 Registrar DHMH 16 Ray 6/95



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	otato o, maryiana	Certificate of Death	Reg. No.	24036								
Physician	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month, Dey	3. Time of Deeth								
/Medical	Ralph Daniel Bartles, Sr.		July-15-199	9 1145 AM								
Examiner	4a Facility Name (If not institution, give street end number)	4b. City, Town, or L										
	Washington County Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last	Hagers t hirthday) If Under 1 Year   If Under 24 Hrs.		shington Co.								
Funeral Director	5. Social Security Number  220-18-1814  Usual Residence of Decedent	Yrs. Months Days Hours Min.	(Month, Day, Year) March13, 1928	9. Birthplece (State or Foreign Country) Maryland								
/and		Town or Location		10d. Inside City Limits								
with the Maryland a or 28a-f show Libe notified at	Maryland Washington County	Hagerstown	1	1 ☐ Yes 2 ☐ No								
vith the Ma	10e. Street and Number	10f. Zip Code	10g. Citizen of Wh	net Country?								
23a c	10729 Oak Forest Drive	21740		USA								
r tems 23s	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuben, Mexican, Puerto	Decify Yes or No- Biack.	- American Indien, , White, etc.								
by	1 Never Married 2 Married 1 7 Yes 2 No 1946 3 Widowed 4 Divorced 1 Yes, Give Year or Dates: 1946	- 1□ Yes 2♥ No Specify:	Specify:	White								
72 ho	15. Decedent's Education (Specify only highest grede completed)	6a. Decedent's Usuat Occupation (Give kind of work done during most of work	16b. Kind of Busi	iness/industry								
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228 1	Herman Samuel Bartles	19b. Mailing Address (Street and Number or Ru	C. Hamby	Neto Zin Codel								
of 2 sho												
Heall Heall	Etta Louise Slayman Bartles, Wife	a of Disposition (Name of		Dity or Town, State								
Pages nent of I int: If Its Iry or o	1 Burial 2 Cremation 3 Removal from State	etery, crematory or other place) dar Lawn Memorial Parl										
nit. Pa artmen ortant: Injury &	4 Donetion 5 Other (Specify)  21. Signature of Funeral Service Licensee			Own, Paryrand								
Departm Departm Importer any Inju	Kelly a gimmermen	22 Name and Address of Facility Douglas A. Fiery 1331 EAstern Blvd.	Funeral Home N., Hagerstown,	Maryland 2174:								
Physician /Medical	23a. Pert1. Enter the disease, or complications that caused the death. I shock, or heart fawere. List only one cause on each line.  tmmediate Cause (Finat			Approximate Intervet Between Onset and Death								
Examiner	disease or condition resulting in death)  Due to (or as	s a consequence of):	-500	1 -4275								
je je	timediate Cause (Final disease or condition resulting in death)  Previous Aproxia  Due to (or as a consequence of):  b. Clivonic Obstructive (unp Disease Years)											
m and laft-transit Examiner	Sequentially tist conditions.  Due to (or es	s e consequenca of):	equenca of):									
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ste has been a page 2 should			performed?	available prior to completion of cause of death?								
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€ 8 a	25. Was case referred to medical	•		IL 162 ZLINO								
This certifical director	examiner?	Other	ath (Check only one)  Iome 5 ☐ Residence 6 ☐ Other	(Specify)								
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after des Director I in by th	3 Sulcide 6 Could not be determined 28e. Placa of Injury - At home building, etc. (Specify)	a, farm, street, factory, offica	28f. Location (Street and Number City or Town, State)	r or Rural Route Number,								
To the Hospital or Attending Portion 24 hours after death of the Completely filled in by the funer Medical Certification:	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowle 2 Medical Examiner: On the basis of examination end menner steted.	dge, death occurred at the time, date and placa end/or investigetion, in my opinion, deeth occu	, and due to the cause(s) and men rred et the time, date and placa, ar	ner as stated. nd due to the cause(s)								
To the Hos within 24 hr To the Fun completely Medica	29b. Signature and title of certains	29c. License number	29d. Date signed	(Month, Day, Year)								
- 3 - 5	my my	A18127	7/14	'00								
	30. Name and address of person who completed cause of death (Item 23	· ·	115/	75'								
		11 St. Haperstrum	md 217	40								
State	31. Date filed (Month, Dey, Year) 32 Solistrer's Signature	8 6										
State Registrar	e.c. su mD 370 Mil	11 St. Haperstown	md 217	40,								



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Yeer **Physician** STEPHANIE SUROWITCH BAUK 4b. City, Town, or Location of Death 15, 1999 4:40 AM /Medical 4a Fecility Nama (If not institution, give street end number) 4c. County of Death **Examiner** REEDERS MEMORIAL HOME BOONSBORO WASHINGTON 6. Dete of Birth (Month, Dey, Year)
FEB. 14, 1 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthdey) 5. Sociel Security Number Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🖾 F Yes 150-18-2136 83 1916 NEW JERSEY Director Usuel Residence of Decedent 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits 1 N Yes 2 No Director MARYLAND WASHINGTON BOONSBORO 10f. Zio Code 10g. Citizen of What Country? 10e. Street and Number 141 SOUTH MAIN STREET 21713 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Biack, Whife, etc. 1 Yes 2 No
If Yes, Give
Yeer or Dates: 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: Specify. þ 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be lited with Department of Health and Mental Hygiene Important: If item 27 is marked other that any injury or other traumetic event, trained blace. 10 HOSTESS PUBLIC MUSEUM 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be JOSEPH SUROWITCH MARY DZIOBKO 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) THOMAS BAUK/GRANDSON 8635 PETE WILES ROAD, MIDDLETOWN, MARYLAND 21769 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 MCremetion 3 ☐ Removel from Stete 4 Donetion 5 Other (Specify) 7/15/99 SMITHSBURG, MARYLAND SMITHSBURG CREMATORY 21. Signature of Furieral Service License 22. Name and Address of Facility 7606 Old National Pike Paul M. Dean BAST FUNERAL HOME Boonsboro, Maryland 21713 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heer failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel diseese or condition resulting in death) Examiner Physician/Medical Examiner physician and s the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of Due to (or as e consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 20 No 3 Probably 4 Unknown 1 Yes bengis be det þ 24b. Were autopsy findings available prior to Completed 24e. Wes an eutopsy performed? completion of cause 1 Yes 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Satural 2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 24 hours Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the Hosp within 24 ho To the Fund completely f (Check only one) 29b. Signet and fitle of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print) Dr. Zafar Malik 20311 Lappans Road, Boonsboro, Maryland 21713/ 301-432-8470 31. Date filed (Month, Dey, Year) 32/Registrer's Signeture JUL 1 6 1999 Registrar

**DHMH 16 Rev 6/95** 

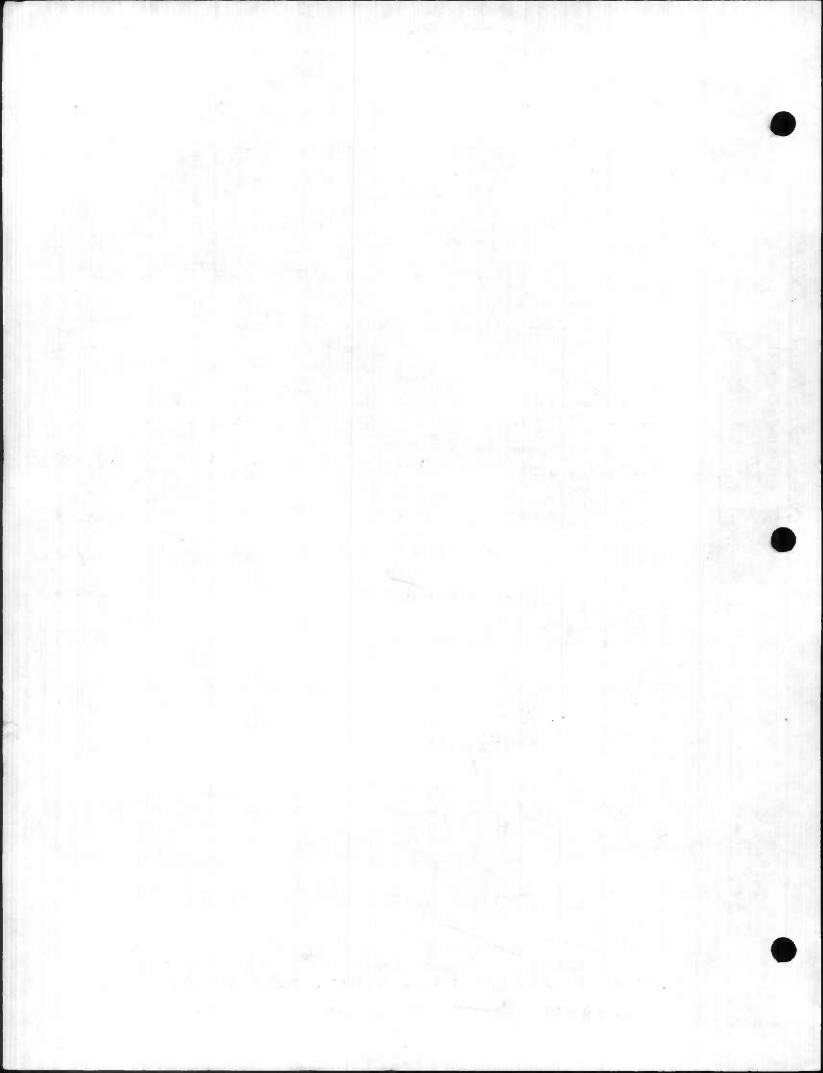
Name: Stephanie

that the death certificate be axecuted

Box 68760.

P.O.

Division of Vital Records.



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1999 Physician Mary Elizabeth BARR Jul /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street end number) Examiner Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) July 23, 1 Birthplace (Stete or Foreign Country) 5. Sociel Security Number 7. Age (In vrs. last birthdev) **Funeral** Min 1 M 2 X F Months Days Hours 66 Yrs. 1932 Maryland 220-26-5386 Director Usual Residence of Decedent Peges 1 end 2 should be filed within 72 hours after death with the Meryland nent of Heatth and Mental Hygiene. nn: If Item 27 is marked other than "natural; or items 23s or 28s-f show 10a State 10h County 10c. City. Town or Location 7 is marked other than "natural", or items 23s or 23s-f show traumatic event, the Medical Examinar must be notified as Maryland Washington Hagerstown Director 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 712 Guilford Avenue 21740 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: g 3 ₩ Widowed 4 Divorced Yeer or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) 0 homemaker her own

0 - 1017. Father's Name (First, Middle, Last)

Roy M. Shetron

Mary E. Golden

18. Mother's Name (First, Middle, Meiden Sumame)

19a. Informant's Name/Relationship (Type, Print) Mr. Wesley B. Barr/son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. Box 712, Funkstown, Maryland 21734

20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Rest Haven Cemetery

Date 20c. Location - City or Town, State July 13, Hagerstown, Maryland

4 Donetion 5 Other (Specify) 21 Signature of Funeral Service Licenses

22. Name and Address of Facility

Minnich Funeral Home

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line.

415 East Wilson Blvd., Hagerstown, Maryland 21740

**Physician** /Medical Examiner

Examiner

Physician/Medical

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Completed

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Certification:

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Department of Health a Important: If item 27 is any injury or other train once.

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Director: A

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To the Hosp within 24 hos To the Fune completely fi

director

funeral

that the death certificate be executed

Elizabeth

Barr, Mary

Division of Vital Records,

or Attending Physician:

death.

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3. Time of Death

0205

10d. Inside City Limits

white

XXYes 2□No

Immediate Ceuse (Finel disease or condition resulting in death)

Due to (or as a consequence of)

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24e. Was an autopsy

24b. Were autopsy findings available prior to completion of ceuse of death?

1 Yes 2 No

1 ☐ Yas 2 ☐ No

25. Was cese referred to medical examiner? 1 Yes 2 No 27. Manner of Death

1 Inpatient 28a. Date of Injury (Month, Day Year) 5 Pending Investigation

28b. Time of

2 ER/Outpatient 3 DOA 28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28d. Describe how injury occurred

26. Place of Death (Check only one)

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 281. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifie (Check e one)

1 Natural 2 Accident

3 Suicide

4 | Homicide

1 Offilfying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner es stated.

Medical Examinar: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signat

6 Could not be determined

29c. License number

1 TYes 2 □ No

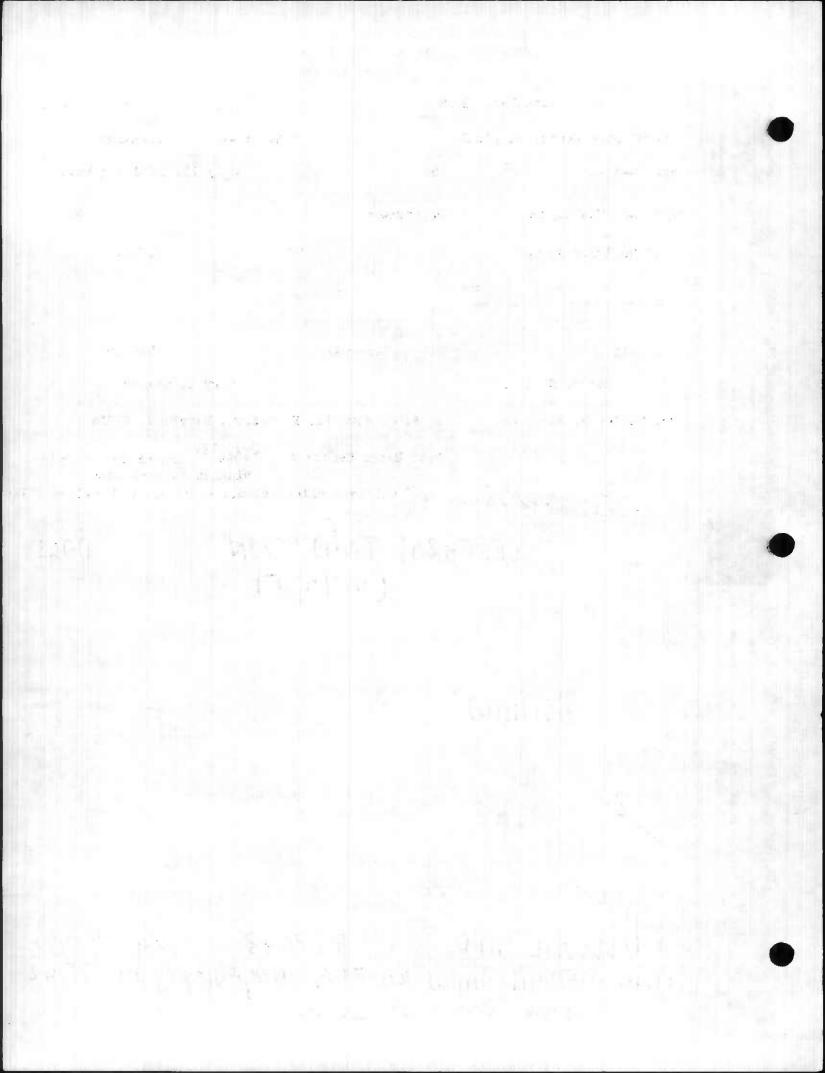
29d. Date signed (Month, Dey, Year)

31. Date filed (Month, Dey, Year)

JUL 1 3 1999

32. Registraus Signature

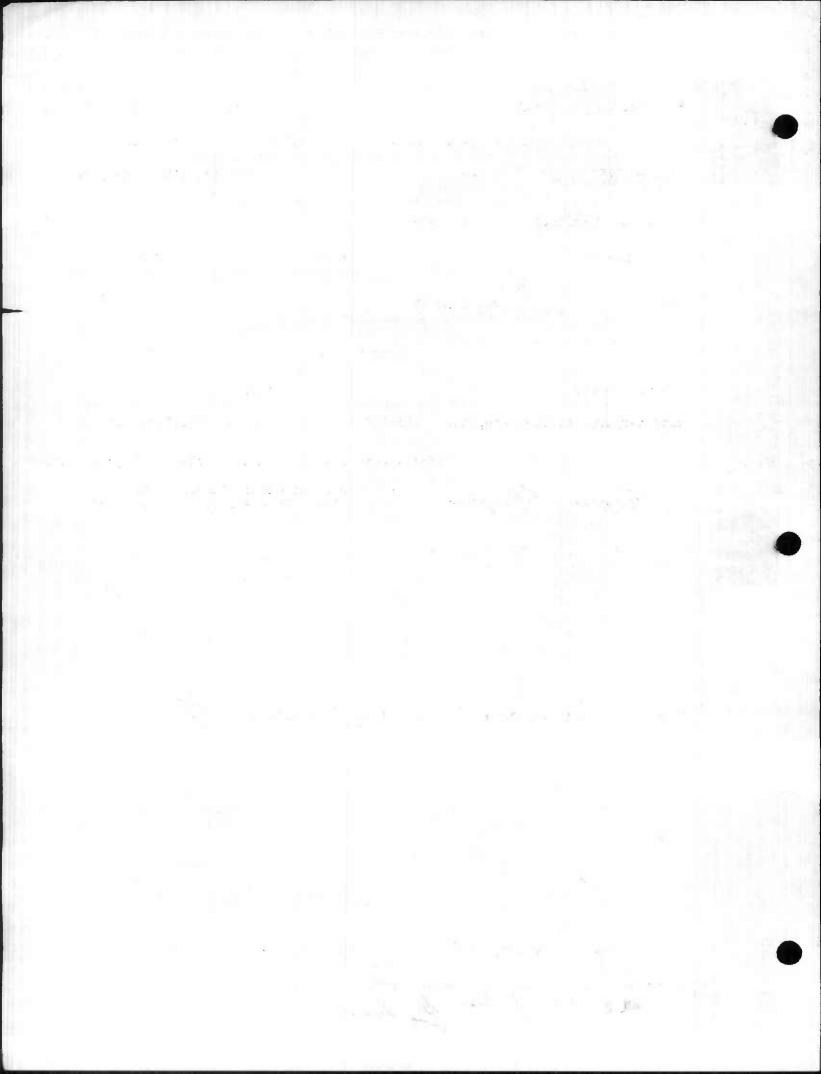
State Registrar



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State of Maryland / Department of Health and Mental Hygiene 2 4 0 3 9

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	Physic		Benedict Joseph	Buckle Sr.						Month July	Day 19,	1999	5:00	AM
	/Medi Examii		4a. Facility Nama (If not institution, g	757 75				4b. City, To	own, or Lo	cation of Death	4c. Count		3.00	
	LXaiiiii	ici		14024 Oa	lel an	a pa		Ridge	137		Carol			
1	Francis		5. Social Sacurity Number 6.			ast birthday)	If Undar 1 Yas			8 Data of Birth		-	olaca (Stata	or Foreign
	Funeral Director		215-26-5752	1₽M 2□ F	66	Yrs.	Months Day		Min.	8. Data of Birth (Month, Day,	Year)	Cour	ntry)	Or Foraigi
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1	8 8	Director	10e. Street and Number	ile	Ridg	ету	10f, Zip Code			1	0g. Citizen of	What Cour	ntn/2	
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0-00-0	He He	Funeral	11. Marital Status	12. Was Decedant Armed Forcas?		5. 13.1	Was Decedant of If Yas, specify Cu	iban, Maxica	n, Puarto	Rican, atc.)		ce - Amario ick, Whita,		
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2 6	ometric removes and death with the may rail plane. Then "natural", or frems 23s or 28s-f show the Medical Examinet must be notified as	Completed	15. Decedant's l (Specify only highast g	ada complated)		(Giva	dant's Usual Occ kind of work don DO NOT usa rati	upation a during mos	st of worki	ing	16b. Kind of B	susinass/in	dustry	
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Daniel Breef	Department of I Important: If Its any Injury or of once.		4 Donation 5 Other (Spec		Ri	dgely	Cemeter	У	J	uly 2219	999 F	Ridge	ly,Mar	rylan
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2	within 24 hours To the Funeral completaly filled	edicai	29a. Certifiar 1 ☐ CertifyIng P (Check only one) 2 ☐ Medicai Exs	hysicisn: To the best of miner: On the basis of	axaminat	viadga, daatr ion and/or inv	occurred at that vastigation, in my	tima, data ar opinion, dat	nd place, a ath occurre	and dua to tha ca ad at tha tima, d	ausa(s) and mate and and attailed and place,	annar as s and dua to	tated. tha ceusa	(s)
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			Caren Moffett	Daffin Ln	Dent	on, Ma	ryland	21629						
	Sta	ite	31. Data filed Wonth, Day, Year 1990	32. Registr			1 .							
	Registr		201 S T 1998	Light	-/	D. A	park							



				Certifica	ate of	Death		Reg. No.					
Physician	Decedent's Neme (First, Middle, L. James		CLARK				2. Dete of I	Day	Yeer 6.27 pm				
/Medical Examiner	4e Fecility Neme (If not institution, gi	ve street end number)				4b. City, Town, o	00010						
	Washington Count	y Hospital				Hage	rstown	Wash	nington				
neral ector	213-24-9828	Sex 7. Age 1. IX M 2 □ F	e (In yrs. last bin 70	Yrs. If Uni	der 1 Yea ns Deys		n. (Month, L	Dey, Year)	9. Birthplece (Stete or Foreig Country) Maryland				
Director	Usuel Residence of Decedent  10e. Stete 10b. County		10c. City, Town	n or Location					10d. fnside City Limit				
ctor	Maryland Washin	gton	,	gerstow	m				1 ☐ Yes 2X N				
Il Director	10e. Street and Number 131 Harvard Roa	d		10f.	Zip Code	21742		10g. Citizen of V	•				
Funeral	11. Marital Status	12. Was Decedent	Ever in U,S.	13. Was De	cedent of	Hispanic Origin? ban, Mexican, Pue	(Specify Yes or I	a - American Indien,					
by	1 ☐ Never Merried 2 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 ⊠ Yes 2 □ h  If Yes, Give  Yeer or Detes:	1°950–51		2 No		eno Hican, etc.)	Specify	ck, White, etc. white				
ted	15. Decedent's E (Specify only highest gi		16e.	Decedent's U	suel Occi	upetion e during most of w	ende in a	16b. Kind of Bu	usiness/industry				
Completed	Elementery/Secondary (0-12) 0-12	College (1-4or 5	i+)	asses	T use retir	e during most of w	orking	State of Maryland					
BeC	17. Fether's Neme (First, Middle, Las	1)			ne)								
To	Lloyd Al	bertus Cla	rk				Mellie	Regina I	Fisher				
	The same of the sa	19e. Informent's Neme/Reletionship (Type, Print)  19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete  131 Harryand Road Hagenstown Mary Land											
	Mrs. Joann B. Clark/wife 131 Harvard Road, Hagerstown, Maryland  20e. Method of Disposition (Name of Dete 20c. Location - City												
	1⊠ Buriel 2 □ Cremetion 3 □ Removel from State 4 □ Donetion 5 □ Other (Specify)  Rest Haven Cemetery  July 20 1999  Hagerstown												
	21. Signature of Fusieral Service Lice	insee	4	22. Name	end Add	ress of Fecility		h Funeral					
DUCE	Septi	nan	murde	415 E	East	Wilson B	1vd., H	agerstown	n, Maryland 21				
	23a. Pert1. Enter the diseese, or cor shock, or heert failure. List only	nplications that caused	the death. Do	not enter the m	node of dy	ying, such es card	iac or respiretory	errest,	Approximete Intervel Between				
1	Shook, of hook lander. Elst on	7 0110 00000 017 00011 111	10.						Onset end Deeth				
	fmmedlete Ceuse (Finel diseese or condition	· Floot	romech	mical	COM	chac des	pocioti		20 mins				
	resulting in deeth)		Due to (or es e	consequence	of):								
xamlner		o. Perut	onitis						2 days				
	Sequentially list conditions, if env. leeding to immediate		Due to (or es e	consequenca	of):								
E I	cause. Enter Underlying Ceuse (Diseese or Injury	c											
odio	thet initiated events resulting in death) Last		Due to (or es e o	consequence o	of):								
3		d											
by Physician/Medical	Pert II. Other signiffcant conditions	contributing to death hi	ut not resulting in	the underlyin	g cause o	given in Pert I.	23b. D	ld tobacco use co	ntribute to the cause of deat				
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by F	congestive 1	east failur	2						•				
Completed	Obstructiv	e lung de	sease				24a. W.	es an autopsy rformed?	24b. Were autopsy findings eveileble prior to completion of ceuse of death?				
mo	Parialisa	> - · · · /	4.				1[	Yes 20 No	1 ☐ Yes 2 ☐ No				
Be C	25. Wes case referred to medical	- Como	asease	-		26. Plece of D	eeth (Check onl	y one)					
70	exeminer? 1 Yes 2 No	Hospital:	ent 2 ER/Ou	tpetient 3	DOA C	other: 4 Nursing	Home 5□Re	sidenca 6 Oth	ner (Specify)				
catio	1 Naturel 5 Pending (Montin, Dey Year) Injury Work? 2 Accident Investigation M 1 Yes 2 No												
Certification:	3 Sulcide 6 Could not be determined 28e. Pleca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 28f. Location (Street and Number or R City or Town, Stete)								ber or Rural Route Number,				
Medical Certifi	(Check only 2 Medical Exa		examinetion an-	, deeth occurr	ed et the	time, dete and ple	ce, end due to the	ne ceuse(s) end m	enner es stated. and due to the cause(s)				
D.	one)	and menner ste											
Σ	29b. Signeture end title of certifier				29c Line	nse number		29d Data signa	d (Month, Dey, Year)				

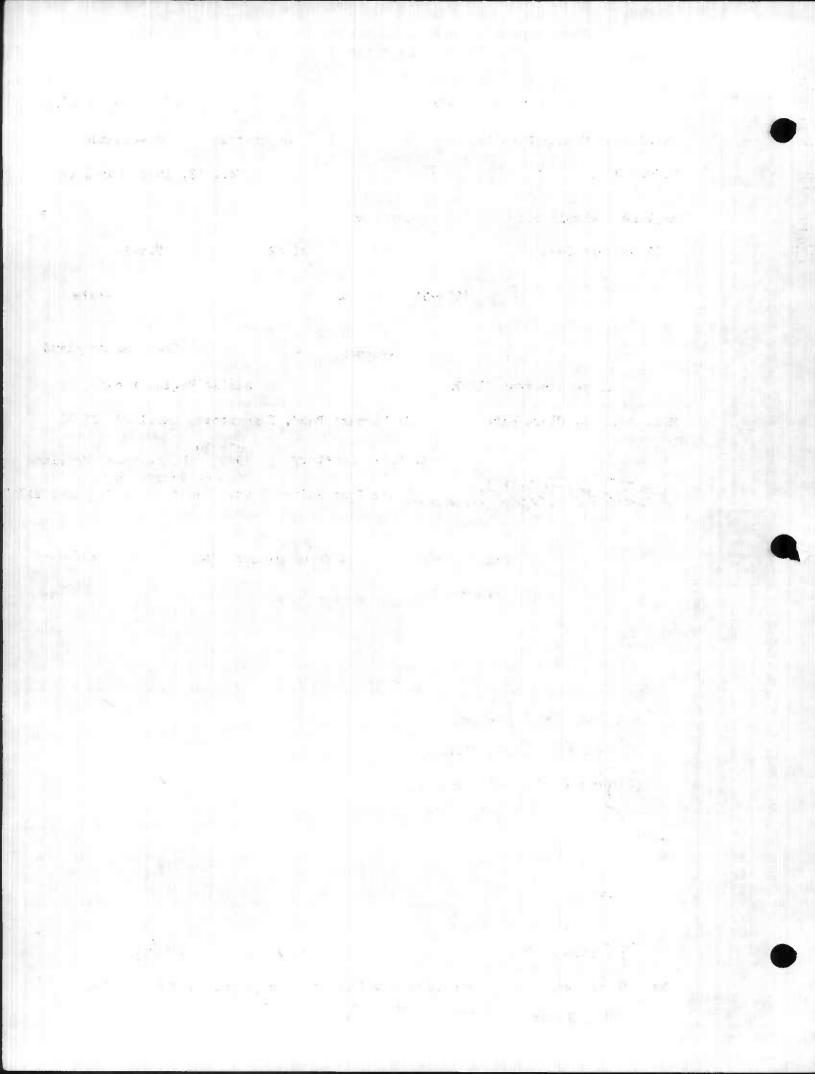
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kelli A Strause MD 747 Non Thurn Quenue Hagerstown MD 21742

31. Date filed (Month, Day, Year)

1111 1 0 1999

A. Aparelli



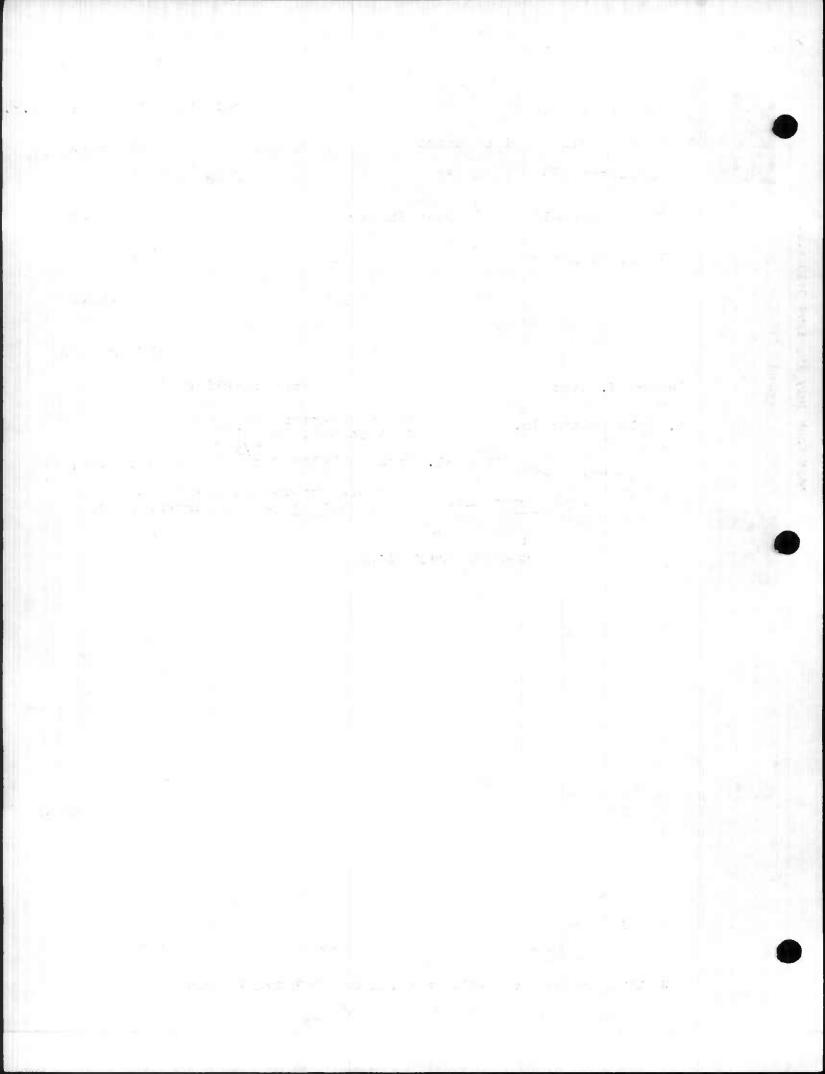
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

					Certifica	te of	Death		Reg. No.	m" from	404	
D1		1. Decedent's Neme (First, Middle, Las	st)					2. Dete of De	eth	V	3. Time of E	Death
Physicia /Medic		Mark Joseph (	Case					July	15 1	Yeer .999	2:45	a.r
Examin		4a. Facility Neme (If not institution, give				4	b. City, Town, or L	ocation of Deeth	4c. County	of Deeth		
		Stella Maris H	Hospice Ce	nter			Timoni	11 700	Bo	ltim	220	
Funeral		Sociel Security Number     6. S		yrs. iest bi	irthdey) if Under	Deys	Timoni If Under 24 Hrs. Hours Min.	8. Dete of Bir (Month, Da	th		ce (Steta or	Foreign
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sho	5	MD Carrol			minste	n				10	d. Inside City	
Ne N	Director		L J.	Mesc								: [3 140
death with the Maryland me 23a or 28a-f show must be notified at	눕	10e. Street end Number				ip Code			10g. Citizen of		y?	
234	La	ll Wimert Aver				2115	•		US			
	Funerai	11. Maritel Status	12. Wes Decedent Ever Armed Forces?	in U,S.	13. Was Deci	ecify Cuba	Ispenic Orlgin? (Si in, Mexican, Puert	pecify Yes or No Rican, etc.)	- 14. Had Ble	ce - America ck, White, et		
0 0 5	by F	1 Never Merried 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give ♣ Yeer or Detes:		1 🗆 Yes	2 No	Specify:		Specif	v: Wh:	ite	
hou		15. Decadent's Ed		169	. Decedent's Us	iel Occur	ation		16b. Kind of B			
permit. Pages 1 and 2 should be filed within 72 hours beatment of Health and Mentel Hygiene. Important: if Item 27 is marked other than "naturet, any Injury or other treumatic event, the Medical Ex-	Completed	(Specify only highest gre	de completed)		(Give kind of w	ork done o	during most of wor	king	100. Kind of b	usiriess/iriuc	olly	
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ente ente c ev	ToB	Edward W. Case					Emma Y	inglin	g			
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oral filled		29a. Certifier 1 X Certifying Phy	ratains. To the best of au	. lea a la da a	- death a	l -a ab - a?						
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		20 Norman / 71	-			743	725		///	0/17		
		30. Name and address of person who c										
		DR. TARIQ MAHMOOI  31. Date tiled (Month, Day, Year)	D 2300 DULA 32. Registrer's S		ALLEY R	D. :	"IMONIUM,	MD 210	93			
State				ATHERITOR								



State of Maryland / Department of Health and Mental Hygiene 99 24042

					Certificate	of Death		Reg. No.		1 6.0
		1. Decedent's Name (First, Middle, La	st)				2. Data of Do	eath Day	Yaar	3. Tima of Death
	Physician /Medical	Donald Raymo	ond CATTS	, Sr.			July	17, 19	99"	12:44 am
	Examiner	4e Fecility Nema (If not institution, giv University of MD		stem			m, or Location of Dee imore	th 4c. County	of Death	
	Funeral Director	5. Social Security Number 6. S 213 40 9646		(In yrs. last birth	day) If Under 1 Months	Year If Under 2 Days Hours	Min. 8. Date of Bi (Month, D March	3, 1941	9. Birthpl Count MD	laca (Stete or Foreign try)
	2	Usual Residence of Decedent								
	vith the Maryler or 28s-1 show be notified at Director	MD County Calvert		10c. City, Town	wings				10	0d. Inside City Limits 1 ☐ Yes ZZ No
	or 28	10e. Sfreet and Number			10f. Zip C	ode		10g. Citizen of	Whet Count	try?
	th wi	2065 Clearview	Drive			20736		U	SA	
21215-0020	n 72 hours effer deeth with the Maryland "natural", or items 23a or 28a-f show edical Examiner must be notified a	11. Marital Sfetus  1 □ Navar Married 2 ☒ Married  3 □ Widowed 4 □ Divorced	12. Wes Decedent Ev Armed Forces? 1 Yas 2 X No If Yes, Give Yaar or Detes:		13. Wes Decede If Yas, specif		in? (Specify Yas or N Puerto Rican, etc.)		ce - America ck, Whita, a y: Whit	atc.
9	2 hou	15. Decedent's Ed	ducation	16a. l	Decedent's Usuel	Occupation		16b. Kind of B	usiness/Ind	Justry
215	C 1 M	(Specify only highest gre	de completed) Coilege (1-4or 5+)		Give kind of work life. DO NOT use	done during most retired)	of working			
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D	生工有 2 中	17. Fether's Name (First, Middle, Last)	)			18. Mother	's Neme (First, Middle	, Meiden Sumer	ne)	
lar	should be nd Mentel marked o nmartic ev	Raymond Dulane	y Catts			Anna	Rita Ma	rshall		
Maryland	do d	19e. Informent's Name/Relationship ( Margie Catts (wi			Meiling Address (		r or Rural Route Numi	ber, City or Town	Stete, Zip	Code)
	T P E	20a. Method of Disposition		20b. Plece of	Disposition (Neme	of	Date	20c. Location	- City or To	wn, Stete
Baltimore,	8077	1 ☐ Burial 2 🗽 Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specif	y)		cremetory or oth plitan C	rematory	7-18-99		-	
Bal	permit. Pag Department Important: I any injury o	21. Signature of Funeral Service Ligar	1 AS			Address of Fecility Funeral		ngs, MD	2073	36
	- 111	Pert1. Enter the disease, or com shock, or heart feilure. List only	plications that caused the	ne deeth. Do no	ot enter the mode	of dying, such es	cardiec or respiretory	errest,		Approximata Intervai Between
50,	ding physician end ges as the buniel-frensit	Immediate Ceuse (Finel disaese or condition resulting In death)  Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury			onsequence of):  CELL onsequenca of):	CARCIN	CANCER			
ox 68760,	certificate be executed ving physician end isse as the buriet-trensition.	thet initiated events resulting In deeth) Last	d	ue fo (or es e co	ensequence of):				1	
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P.O.	d by the etach	Pert II. Other significant conditions of						Yas 2 No		the cause of death?
of Vital Records,	been sign should be	PNEUMONIA						s en eutopsy formed?	ave	ere eutopsy findings eilable prior to mpletion of cause death?
Re	The law ate hes pege 2						10	Yes 2 No	10	Yes 2K No
ta		25. Was case referred to medical				26. Place	of Deeth (Check only		1	
>	F	examiner?	Hospifai:	2 ER/Out	petient 3 DOA	Other	rsing Home 5 Res		ner (Specifi	v)
	4 4 6	27. Manner of Death  1  Neturel 5 Pending 2  Accident investigation	28e. Date of Injury (Month, Dey	28b. Ti		c. Injury et Work? 1 Yes 2	28d. Dascribe	how injury occur		,
Division	tel or Attending P rs after death. si Director: After t led in by the funer Certification:	3 Suicida 6 Could not b 4 Homicide determined	e 390 Place of Injur	y - At home, fer (Specify)	m, street, fectory,	offica		(Straet end Num. own, Stete)	ber or Rure	I Route Number,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely lilled in by the funeral Medical Certification		yelclan: To the best of niner: On the basis of e end mennar stete	xeminetion end						
	within To th comp	29b. Signeture end title of certifier  Paul Bu	per Roace	R m.	Ø .	License number	8	July		Day, Year) 1999
	10	30. Nema end eddress of person who PANL ROACH M.	completed cause of dea		ype, Print)  REENE	57. 6	PALTIMALE	mo d	21201	,
	State Registrar	31. Dete filed (Month, Dey, Year)	32. Registrer	s Signeture	Á.	Sport				
		JUL #	- 1000			1				

1. Decedent's Nama (First, Middla, Last)

Sara Jane DeLauter

TANE

4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Nama (If not institution, give street end number) Examiner Washington Washington County Hospital Hagerstown If Under 24 Hrs. 8. Dete of Birth Hours Min. Sept. 23,1938 If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthpleca (Steta or Foraign 5. Social Security Number Months Deys 1 M 2 F Maryland 60 Yrs 219-34-5204 Usual Residence of Decedent with the Marylend r 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Frederick Smithsburg Md. 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number "natural", or Itama 23a or 12801 Wolfsville Rd. 21783 U.S.A. death v Funerai 12. Was Decedent Evar In U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indien, Black, Whita, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If Itam 27 Is marked other than "natural", or has any injury or other traumatic avent, the World Experiment 1 Never Married 2 Married White Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary School Board 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Helen Yeager George Shantz 19a. informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clark D. Delauter (Husband) 12801 Wolfsville Rd. Smithsburg, Md. 21783 20b. Place of Disposition (Neme of cemetery, cremetory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burlel 2 Cremation 3 ☐ Removal from Stata July 13, 1999 Smithsburg, Md. Smithsburg Crematory 5 Other (Specify) Signature of Fungral Service Lice 22. Name and Address of Facility 12525 Bradbury Ave. Davis Funeral Home 20 mm00 Smithsburg, Md. 21783 Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical . Atheroscleratic Coronary Artery Disease Examiner Due to (or as a consequence of): Physician/Medical Examiner ng physicien end es the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequenca of): attending USB Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contributa to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown P 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en eutopsy certificate has b 1 ☐ Yes 2 ☐ No filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 □ DOA 28e. Dete of injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: or Attending 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end manner as stated.

Medical Examinar: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier edicai To the Hosp within 24 ho To the Fune completely fi 29d. Date signed (Month, Day, Year) 29c. Licansa number 29b. Signature end title of certifier 2 MD 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) 3019 Ventrie Court Myersuille, MD 21773 Lenzalowski , MD F 31. Date filed (Month. Day, Year) 32. Aegistrer's Signature State

Piease Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2 Data of Death

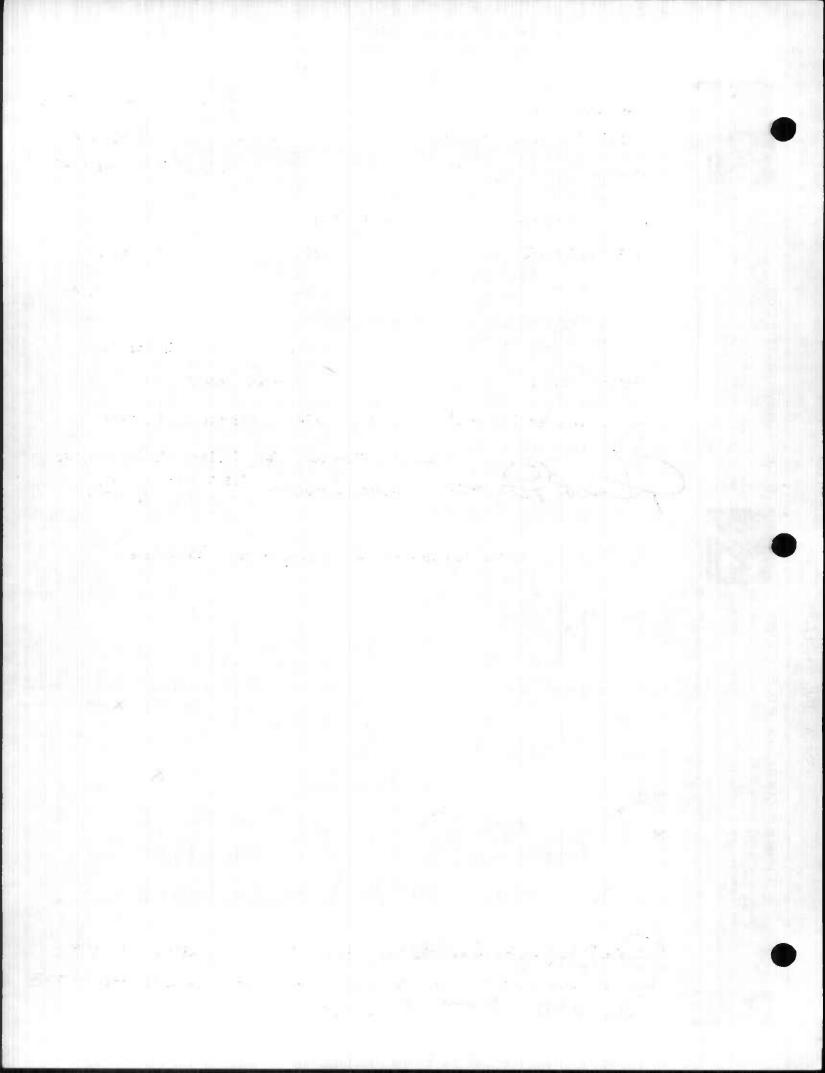
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3. Time of Death

0215

Registrar

JUL 1 3 1999



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 2. Dete of Deeth 3. Time of Deeth Month ancer 2105 07 199 0 48 Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Washington County Hospital Hagerstown Washington If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Y Sept 22, If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) Deys Months 1 ☐ M 2 🖾 F 71 Yrs. 212-24-2889 1927 Maryland Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes MINO Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 13824 Paradise Church Road 21742 u.S.A. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? ☐ Yes 2 No Yes, Give 1 Never Married 22 Merried Specify: White 1 ☐ Yes 2 ☒ No Specify: 3 Widowed 4 Divorced Yeer or Detes: 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) antique shop owner/operator 0 - 1217. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumeme) Roscoe C. Ahalt Clara Pearl 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Mr. George E. Dahlhamer/husband 13824 Paradise Church Road, Hagerstown, Maryland 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c Location - City or Town, Stete 20e. Method of Disposition Dete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State July 11 Hagerstown Crematory 4 ☐ Donetion 5 ☐ Other (Specify) Hagerstown, Maryland 1999 21. Signeture di Europeai Service Licensee 22. Neme end Address of Fecility Minnich Funeral Home 415 East Wilson Blvd., Hagertown, Maryland 21740 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Adenocarcinoma of left Breast with 13 years Immediate Cause (Final diseese or condition resulting in deeth) Due to ( r es e consequence of): Due to (or es e consequence of) 23b. Did tobacco use contributs to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveileble prior to completion of cause of death? 24e. Wes en eutopsy 2 34 1 ☐ Yes 2 ☐ No 1 Yes 26. Piece of Deeth (Check only one)

**Physician** /Medical **Examiner** 

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Department of important: If any injury or

altimore, Maryland 21215-0020

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Examiner Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Physician/Medical the

Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.

25. Wes case referred to medical exeminer? 1 Yes 2 No

1 Hipatient 2 ER/Outpatient 3 DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

Hagerstown

27. Menner of Deeth 1 Naturel 2 Accident 3 Suicide

4 Homicide

28a. Dete of Injury (Month, Dey Year) 5 Pending Investigation 6 Could not be Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier

1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end manner as stated.
2 Medical Examiner: On the best of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end pleca, and due to the cause(s) end menner stated.

29b. Signature end title of certifier

29c. License number

State Registrar

**DHMH 16 Rev 6/95** 

29d. Date signed (Month, Day, Year)

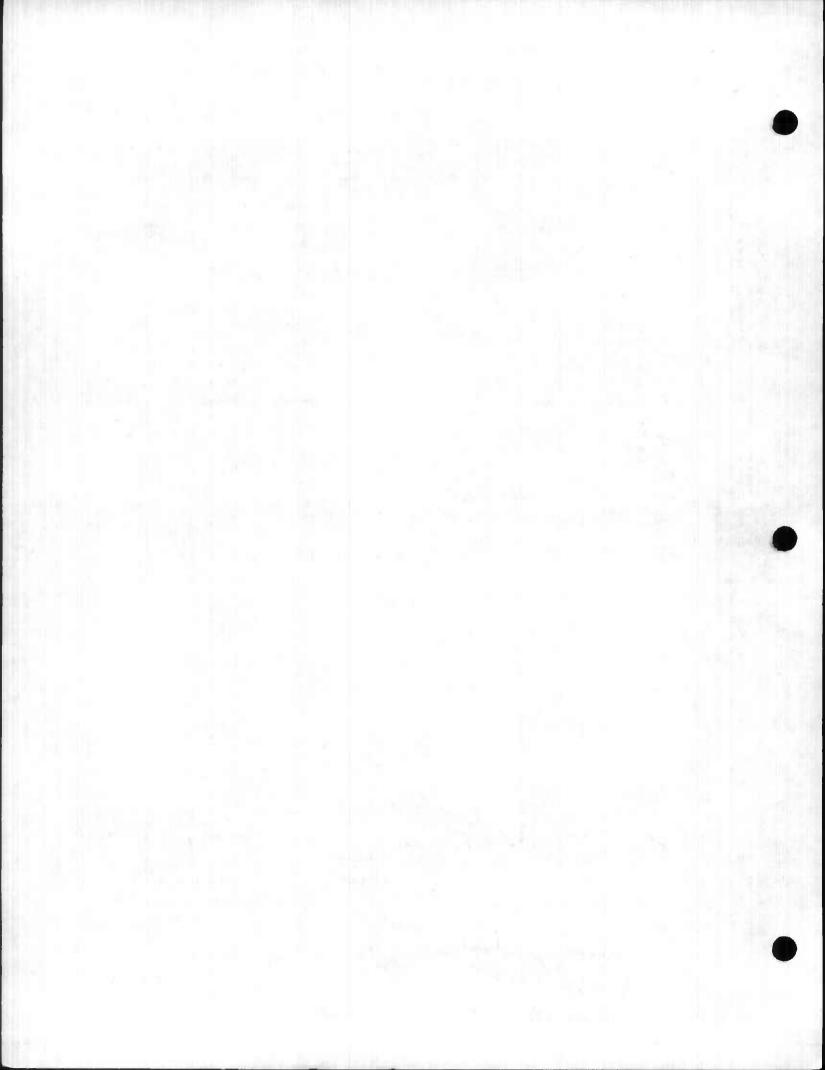
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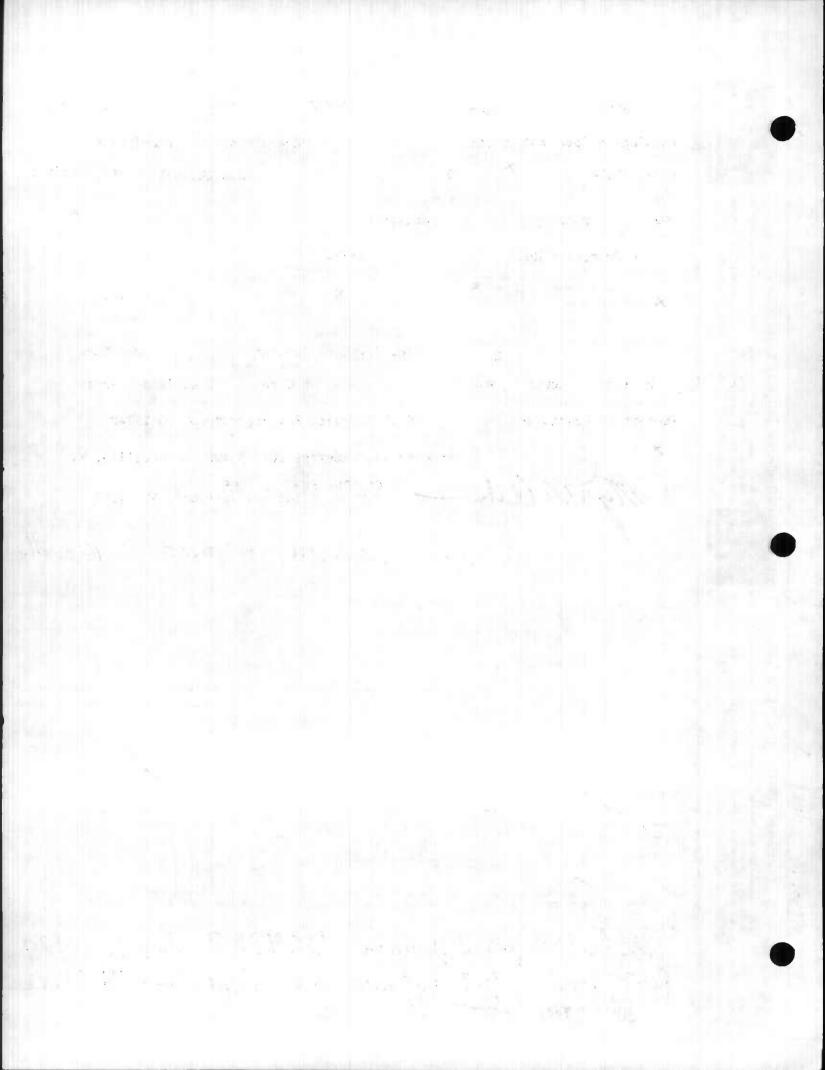
ckson			Certificate	e of Death		Reg. No.	- 6	-4040
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21215-0 ed within 72 ho ygiene. er than "netun ft, tre the deat	15. Decedent's Education (Specify only highest grade co	on impleted)	16a. Decedent's Usual	done during most of w	vorkina	16b. Kind of Bu	sinass/Inc	Justry
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나 등을 나	1 X Yes 2 No Hosp	1 □ Inpatient 2 □ E	R/Outpatient 3 DO/		Home 5 Resid			) Scene
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DIVISION To the Hospital or Attance within 24 hours after death To the Funeral Director: completely filled in by the		n: To the best of my knowl On the basis of examinatio and menner steted.	edge, death occurred a	t the time, date and pla	ce, and due to the	cause(s) end ma	nner as si	
To the To the comp	29b. Signature end title of certifier	Chart		License number		29d. Date signe		
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	30. Name and address of person who complete the second sec	1 1.	23a) (Type, Print) L1 Penn Str	eet, Baltir	more, Mar	yland 2	1201	
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Washington County Hospital Type 1 Service Annual Se		Certificate of Death	Reg. No.
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Social Security Numbers   Social Security		Washington County Hospital Hager	rstown WASHINGTON
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sician edical immediate Cause (Final dieses or considion resulting in death)  Due to (or as a consequence of):  24b. Were autopsy performed?  24b. Were autopsy performed?  24b. Were autopsy performed?  24b. Were autopsy performed?  1   Yes   2   No    1   Yes   2   No    24b. Were autopsy performed?  1   Yes   2   No    1   Yes   2   No    24b. Were autopsy performed?  1   Yes   2   No    1   Yes   2   No    24b. Were autopsy performed?  1   Yes   2   No    24b. Were autopsy prindings available plot to consequence of):  1   Yes   2   No    24b. Were autopsy prindings available plot to consequence of):  1   Yes   2   No    24b. Were autopsy prindings available plot to consequence of):  24b. Were autopsy prindings available plot to consequence of):  24b. Were autopsy prindings available plot to consequence of):  1   Yes   2   No    24b. Were autopsy prindings available plot to consequence of):  1   Yes   2   No    24b. Were autopsy prindings available plot to consequence of):  1   Yes   2   No    2   Accident   2   No			
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26. Place of Deeth (Check only one)  27. Mennar of Deeth 1	32 s.		of death?
26. Place of Deeth (Check only one)  27. Mennar of Deeth 1	page Com		1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No
1   Yes 2   No   1   General Polarity   2   Et/Outpetient 3   DOA   4   Nursing Home 5   Residence 6   Other (Specify)    27. Menney of Deeth 1   1   Meteural 5   Pending Investigation 6   Could not be determined   28e. Deteof Injury - At home, ferm, street, fectory, office   28f. Location (Street end Number or Rural Route Number, City or Town, Steet)    29e. Certifier (Check only one)   2   Madical Examiner: On the basis of examinetion end/or inveatigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) end manner steted.  29c. License number   29d. Date signed (Month, Day, Year)   32/Registrer's Signeture   32/Registrer's S	ctor,	25. Was case referred to medical 26. Place of avaraginar?	of Deeth (Check only one)
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29b. Signature and little of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)  31. Date filed (Month, Day, Year)  32 Registrer's Signature	A fille		plece, and due to the ceuse(s) end manner es stated.
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30. Name and address of person who completed cause of deeth (flem 3e) (Type, Print)  State  31. Dete filed (Month, Dey, Year)  32/Registrer's Signeture	o the	29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)
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State Annual Manager Al		LOCAL DUN 1221 ROLOMAC AVE.	mugers (aun ( (2 21/9)
	State Registrar	31. Dete filed (Month, Dey, Year)  32/Registrer's Signeture  4. Apostor	V

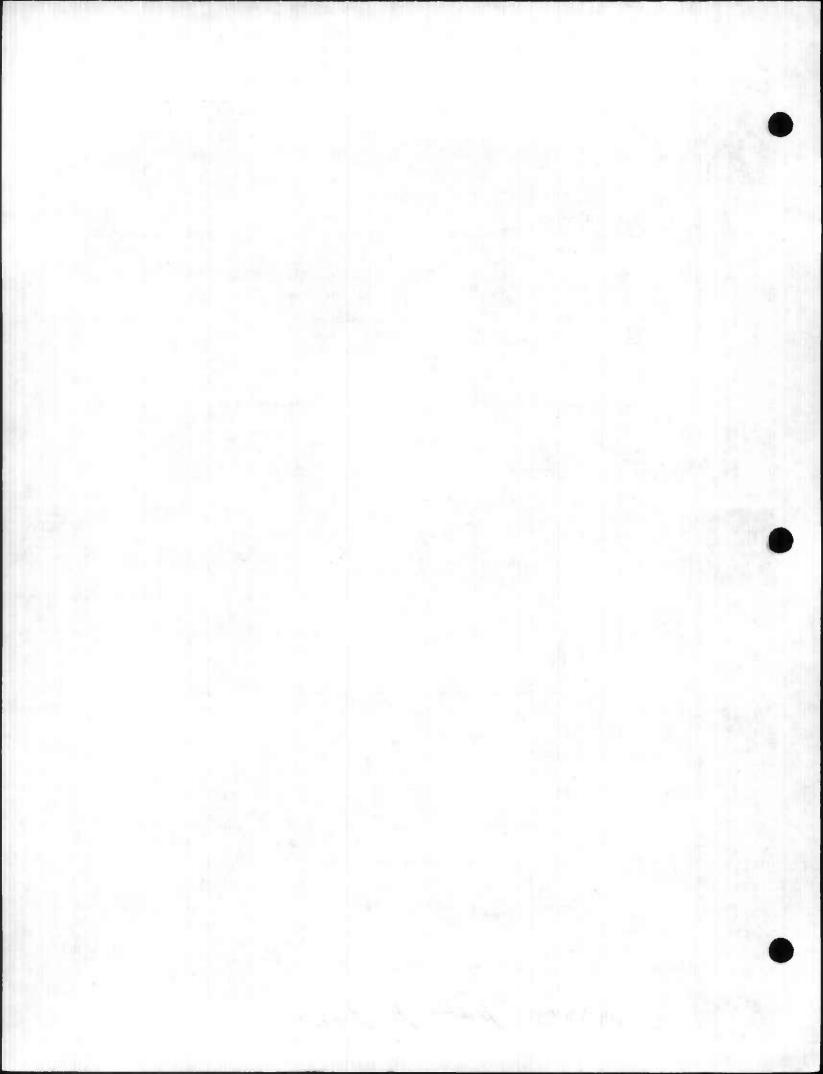
DHMH 16 Rsv 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** NAGINDAS DOSHT JULY 17, 1999 9:35 AM /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Memorial Hospital Frederick 7. Age (In yrs. last birthday) 72 Yrs. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 12, 1 Birthplace (State or Foreign Country) **Funeral** Months Days Min. Hours 11XM 2□ F 220-53-9243 1927 India Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at 1 ☐ Yes 2 No Frederick Union Bridge Directo Maryland 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or flams 23a or 12803 Boxwood Ct. 21791 India Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Merital Status 12. Wes Decedent Ever in U,S. Armed Forces? filed within 72 hours after 1 ☐ Yes 2 🖺 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Indian Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) dairy products manager permit. Pages 1 and 2 should be filed w Department of Health and Mantai Hygien Important: If Item 27 is marked other tha any Injury or other traumatic content tha once. 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumama) Be Maniben Kamdar Harjivandas Doshi 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Manoramaben Doshi/ wife 12803 Boxwood Ct. Union Bridge, MD 21791 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal Irom State 7/18/99 Smithsburg, MD Davis Crematory 4 □ Donation 5 □ Other (Specify) 22. Name end Address of Facility Hartzler Funeral Home 21. Signature of Funerel Service License 11802 Liberty Rd. Libertytown, MD 21762 rine 23a. Part1. Enter the diseasa, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each Approximata Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final months diseese or condition resulting in death) Examiner Examiner attending physician and for use as the bunal-transit certificate be axecuted Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): 88 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. the signed by the 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown þ 24b. Wera autopsy findings available prior to Completed 24a. Was an autopsy performed? peen completion of cause of death? 1 Yas RANO 1 ☐ Yas 2 ☐ No certificate 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) Ne Hospital or Attending Ph n 24 hours after death. Ne Funeral Director: After th 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: Natural 5 Panding investigation 1 Tyes 2 □ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stafa) 6 Could not be 3 Suicide 28e. Plece of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

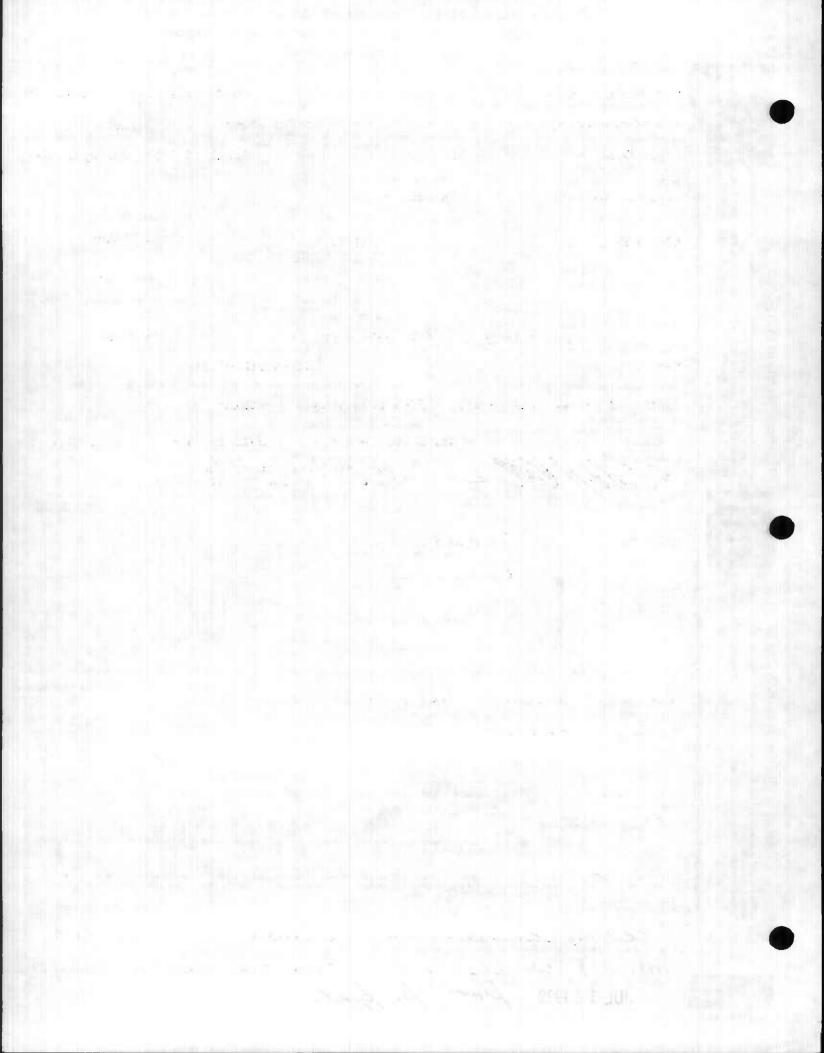
| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only within 2 onel 200 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signal of certifier 4164 HEGAZIIMD 30. Nama and address of person who completed causa of death (Item 23a) (Type, Print) 21701 A.Z. HEGAZI, MD 801 TOLLHOUSE Frederick, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 1 9 1999 Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

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	1. Dec	edent's Name (F	First, Middle, L.	ast)		- 10				2. Date of Do	eath Dey	3. Tim	ne of Deat
Physician /Medical	Jea	anne E.	Donova	n						July	13. 199		07 P
Examiner	4a Fa	cility Name (If no	ot institution, gi	ve street end nu	m <i>ber)</i>			4	b. City, Town, or				
	Rol	osson N	Nursing	Center					Randalls	town	Balt	imore	
Funeral		ial Security Num	nber 6.	Sex	7. Age (In yrs.	lest birth	day) If Unde	r 1 Year	If Under 24 Hrs Hours Min	8. Date of Bi	irth	9. Birthplece (Ste Country)	ete or Fore
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to rot	Mary	land C	Carroll		We	oodbi	ne					10	Yes 2 🔼
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1 E 3		)1 Dorse	av Lane				21	797			United S	States	
r items 234 Ther must Funeral	11. Ma	ritei Sfafus	. J Lane	12. Was Dec	edent Ever in U	,s.			lispanic Origin? (S an, Mexican, Puer	Specify Yes or N	0- 14. Rec	e - American Indie	n,
Hygiene. ther than "natural", or items 23a or 23e-f show ant, the Medical Examiner must be notified at a Completed by Funeral Director		Never Married Widowed 4x		1 ☐ Yes If Yes, Gir Year or D	2 ☑ No /e		1 ☐ Yes		Specify:	to thousand otoly		White	
ted bat		15	5. Decedent's E	ducation		16e. D	ecadent's Usi	ai Occup	etion		16b. Kind of Bu	usiness/Industry	
ygiene. Nr. Fre Medical Completed	Fler	(Specify nentary/Seconde		rade completed) College (	(-4or 5+)	- "	ife. DO NOT	se retire	etion during most of wa d)	rking			
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h and Men 7 Is marke treumatic	19e. fr	nformant's Neme	e/Reletionship	(Type, Print)		19b. l	Mailing Addres	s (Street	end Number or A	ure/ Route Num	ber, City or Town,	Stete, Zip Code)	
= 0 -	Cyr	ithia Sz	ymansk	i (daugh		670	1 Dors	ey L	ane Woo	dbine, 1	MD 21797		
Item 2 r other		lethod of Dispos		75	20b.	Piace of Democratic	isposition (Ne cremetory or	me of other plea	ce)	Date	20c. Location -	City or Town, Stel	te
T. F.		☐ Buriel 2 ☐ C ☐ Donetion 5 [		□Removel from ify)	State		ns Cem			ul. 15.	1999 E1	licott Ci	Ltv.
Depertment of Himportant: If the any Injury or of pince.	21. Si	gnaturu of Fundi	ral Saryice Ligi	msge/22			22. Name a	nd Addre	ss of Facility				
Impo any Ir	- 5	/3/	MI	1,61	_		Burri	er-Q	ueen Fun	eral Hor	me Jinfield	, MD 2178	2/1
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e ettending physician end ad for use es the buriel-fransit sician/Medical Examiner	Seque if any, cause	entially list condition to interest the condition of the	itions, ediate ing	b. P.	vume	hen	nsequence of					i i	
	Ceuse (Diseese or injury thet initiated events resulting in deeth) Last  Due to (or as e consequence of):												
an last			-	d									
ed for use	Part II.	Other significa	int conditiona	contributing to d	eath but not re	suiting in t	he underlying	cause giv	ren in Part I.	23b. Dfc	d tobacco uae co	ntribute to the ca	use of de
ned by the ettending e deteched for use e		Other signiffica					he underlying	cause giv	ven in Part I.			ntribute to the car	
igned by the be deteched by Physical by Ph			me h.	contributing to d				cause giv	ven in Part I.	1 [ 24a. Wa			42 Unk
has been signed by th ge 2 should be deteche mpleted by Phys			me h.	contributing to d				cause giv	ren in Part I.	1 Z4a. Wa	Yes 2 No	3 Probably  24b. Were auto evailable p completior	4 Unk
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his certificate has been signed by the idirector, page 2 should be deteched for the completed by Physical Complete C	25. W. ex	as case referred aminer? Yes 22No enner of Deeth Naturat	d to medical  5 Pending investigation (Could not)	Hospital: 1 28e. Dete	Inpatient 2E of Injury	ER/Outp	netient 3 Dene of	OA Oth	26. Plece of Dener: 42 Nursing	24a, Waper  1	yes 2 No is en eutopsy formed?  Yes 2 No r one) sidenca 6 Oth s how injury occur	3 Probably  24b. Were auto evailable p completion of deeth?  1 Yes	42 Unk
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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle. 2. Date of Death 10×1 & Therine 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 6 D Bridgelake Circle **Baltimore** Cockeysville If Under 1 Yaar If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 F Months 40 212-52-4546 Yrs. MDUsual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Cockeysville 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 6 D Bridgelake Circle 21030 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Personnel Headhunter Car Rental 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama)

20b. Place of Disposition (Name of hurchyard

22. Name and Address of Facility

108 William St.

St. Paul's Episcopal

Virginia Redman

7/18/99

Berlin, MD

20c. Location - City or Town, State

Approximate Interval Between Onset and Death

Berlin, MD

Burbage Funeral Home

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

45 Abbeyshire Lane Berlin, MD

**Physician** /Medical Examiner

Department of Important: If any Injury or

Baltimore,

Examiner

**Physician** 

/Medical

Examiner

10a State

Director

Funeral

ģ

Completed

MD

**Edmund Nugent Dalton** 

1 Burial 2 Cremation 3 Removal from State

Edmund Dalton/ Father

19a. Informant's Name/Relationship (Type, Print)

4 ☐ Donation 5 ☐ Other (Specify)

20a. Method of Disposition

Immediate Cause (Final disaase or condition resulting in death)

**Funeral** 

Director

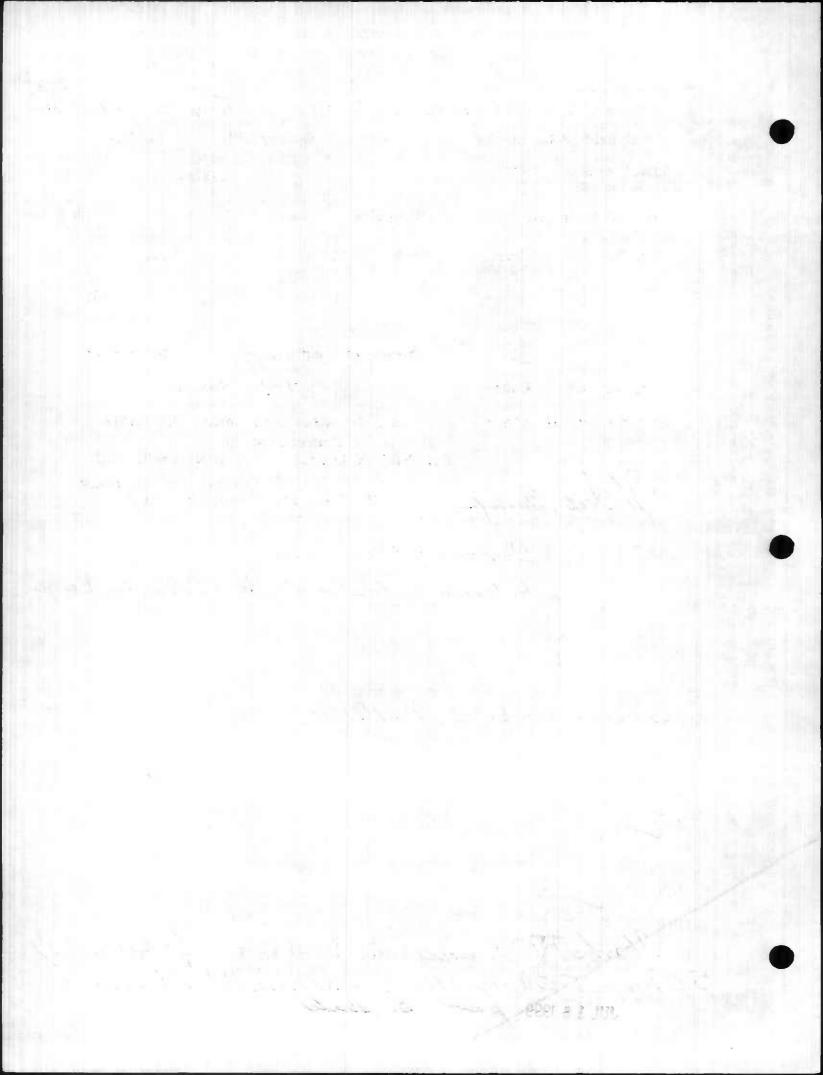
r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

nit. Pages 1 and 2 should be filed within 72 hours after death with narment of Health and Mental Hygiene.

ortant: If item 27 is marked other than "natural", or items 23s or Injury or other traumatic avant, the Modical Examinar must be a

the Maryland

requires that the death cartificate be executed P.O. Box 68760, Division of Vital Records, has certificate Hospital or Attending Physician: After this



					State of	Marylar	nd / Depa	artmen rtificate			and Men		eg. No.	6.4	030
	B1 1-1		ecedent's Name (First, A	Aiddle, Las	1)	7	-5.78	. ,				Date of Deal	th Day	Year	3. Tima of Death
	Physician /Medical	_	Joseph	Fr	meis	1 Dr	1500	//			0	TULV	14,1	999	9- pm
1	Examiner	40 1	Facility Name (Not insti	tution, give	street end nun	nber)			4	b. City, To	wn, or Location	on of Death	4c. County	of Death	
			ST. JOSEPH					T. Killadaa	4.7/222	TOWS				IMORE	
	Funeral		oclal Security Number	6. Sa	X M 2□F		. lest birthday) Yrs.	If Under Montha	Days	If Under :	Min.	Data of Birth (Month, Dey	Year)		ca (Stete or Foreign y)
	Director		31-18-1436 al Rasidance of Deceder			77	110.				02	-14-19	922	NEW YO	JRK
	wo #		State 10b. Co			10c. Ci	ity, Town or Lo	ocation						100	d. Inside City Limits
	Mery de la sh	DE	LAWARE SUS	SEX		м	ILLSBOR	20							1 Yes 2 □ No
	rectined in	10e.	Street and Number	DLIII			LLLDDOI	10f. Zip	Code			1	0g. Citizen of	What Countr	y?
	iter deeth with the Me r items 23a or 28s-1 s iner must be nuttree	49	DERBY WAY					19	966				U.S.	Δ	
	deet	11.	Marital Status		12. Was Dece Armed For	dent Evar in U	J,S. 13.	Was Deced	dent of H	ispanic Original	gin? (Specify	Yes or No-	14. Rad	ce - Amarica ck, White, et	
0	or its		I ☐ Navar Marriad 2🂢		1 DYYes It Yes, Giv			1 ☐ Yes 2		Specify:	,, , , , , , , , , , , , , , , , , , , ,	, στοι,	Specif		
21215-0020	filed within 72 hours after deeth with the Meryland Hygiene. Ther than "natural", or items 23a or 28a-1 show ont, the Medical Examiner must be netfred at a Completed by Filmers! Director	5	3 ☐ Widowed 4 ☐ Divo		Year or De	ates: 194	2								
5-	nath notes		15. Dec (Specify only h	edent's Ed ighast grad			(Giva	dent's Usua kind of wor DO NOT us	rk done o	during most	t of working		16b. Kind ot B	uainess/Indu	istry
12	ed within 72 ho ygiene. her than "naturi ft, the Medical I	E	lementary/Secondary (0- 12	12)	College (1	-4or 5+)	1		20 10[1100	"			DATE	DOAD	
	should be filed withind Mental Hygiene. marked other than imatic avent, the M	17.	T Z Father's Name (First, Mid	ddle, Last)			PRINT	EK		18. Mothe	er's Neme (Fi	irst, Middle,	RAIL: Melden Sumer		
lan	Mental H Mental H arked oth artic aven	D T	ANIEL DRISC	OT.T.						MARC	GARET '	TTERNE	ZV		
Maryland	should and Men marke umartic		. Intormant's Name/Rela		ype, Print)	7.7	19b. Maili	ng Address	(Street				r, City or Town	, State, Zip (	Code)
	1 and 2 Heelth a em 27 is other trau	МА	RTHA J. DRI	SCOL	./ WIFE		49 DE	RRY W	AV.	/ILLSI	BORO.	DELAWA	ARE. 19	966	
ore,	8 - 2 0		Method of Disposition			20b.	Place of Disponentery, cre	osition (Nen	ne of ther place	(e)		Data	20c. Location	- City or Tow	n, State
Ĕ	P P P		1 Burial 2 Cremat								RIAL7-	20-99	BEAR,	DELAWA	ARE
Baltimore,	pemit. Page Department of Important: If any Injury or once.	21.	Signature of Funeral Seg	Wen Ligari	500	)		2. Nama an							
0	20 5 5 8		W SUFE	- 16	61						SERVI		TD. DELAW	ARE. 1	9966
		238	Part1. Enter the diseas shock, or heart fahire.	e or comp	olications that cone ceuse on e	aused the dea									Approximate Interval Between
	Physician		,		D			70							Onset and Death
	/Medical Examiner	dise	nediate Cause (Final		1600	eno	ry	Das	2/4	15/0	227			i	
	No. of Lot of Lo	1	ulting in death)		2-	Due to (	or as a conse	quence ot):		,	1	,	015-	1	
	executed in and vial-transit				Arter	10301	exole	c (0	WH	10 V	2500	1/22	0/5-	ease	
_6	al-train	Sec if an	uentially list conditions, ny, leading to immediate se. Entar Undarlying use (Disease or Injury			Due to (	or as a conse	quence ot):						i	
8760,	cate be executed by sician and the bunal-transit	Cau	se. Entar Undarlying ise (Disease or Injury initiated events	<	c	Due to /	01.00.0.00000	-uonno of):							
68	= 5	)	ulting in death) Last			Due to (	or as a conse	querice or):							
XO	attending for use e				d										
m.	at the death certificate be executed by the attending physician and etached for use es the burial-transit bhyeiclan Madical Examin	Part	II. Other significant cor	nditions co	ontributina to de	eath but not re	sulting in tha	ınderivina c	ause giv	en in Part I	1.	23b. Did to	obacco use co	ontribute to	the cause of death
P.0	ed by the detached											101	fes 2□ No	3 Prob	abiy 40 onknow
S,	5 60														
Record	been sign should be	2										24a. Was a perfor	an autopsy med?	ava	re autopsy tindings ilable prior to apletion of cause
ecc	aw sp sp sp	<u> </u>													eeth?
	The la	3										1 □ Y	es 2 No	1 🗆	Yes 20 No
Vital	delan: The certificate rector, pag		Was case reterred to me								e ot Death (C	check only o	ne)		
5	Physician: this certific ral director,	-	1 Des 2□ No		1		ER/Outpatie			4 LI NU			lenca 6 🗆 Oti		)
	on of the t	27.	Manner of Death 1 ☑Natural 5 ☐ Po	ending		ot Injury h, Dey Year)	28b. Time of Injury		28c. Injur Wor			l. Describe h	ow injury occu	rred	
sio	Attending r death. ector: Afte by the fune			vestigetion ould not be		41.1. 41.1	1	M		Yes 2□		Location (6	Street and Num	har or Qural	Coute Number
Division	rs efter death. al Director: After ted in by the funera			etermined	286. Place	ng, etc. (Spec	nome, farm, st ify)	reet, factory	у, опісе		201.	City or Tow	n, Stete)	Der or Hurer	Route Number,
_			. Certifier 1 Cer	tifvine Dh	ysician: To the	hast at my ka	owledge desi	h occurred	at the ti-	ne date en	nd niece and	due to the	euse(s) end m	enner se et	ated
	Hospi 24 hours Funer Hely fill	256			iner: On the ba										
	To the To the comple		Signature and title of ce	srtifier c			-	290	c. Licens	e number		1	29d. Dule sign	ed (Month, E	Day, Year)
	F 25 0		Cha	0	100	000	0000	7-7	7-1	093	83		Test	41.4	1999
		30,	Name and address of pe	rson who o	completed caus	e of death (Ite	m 23a) (Type	Print) /	1/1	Lin	nlet	NA	TDJ/	7.0	1
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D. Sparke

DHMH 16 Rev 6/95

State

Registrar

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State of Maryland / Department of Health and Mental Hygiene

					ertifica	e of	Death		Reg. No.	3 6	4001
		1. Decedent's Name (First, Middle, Last,	)					2. Date of De		Year	3. Time of Death
	hysician /Medical	WILLIAM B.	ELLIOTT					July	18/1	999.	0356
	xaminer	4a Facility Name (If not institution, give	. 1				4b. City, Town, or I	ocation of Deet	th 4c. County	of Deeth	
<u> </u>		744-4-7-	HOSPITAL				Berlin		1 4 4-	resiel	
	neral ector	217 30 3700 7	X 2□ F 7. Age 6	(In yrs. last birtho	Months	Days		8. Date of Bi (Month, Di	rth ay, Year) 4, 1937		e (Stete or Foreign and
pue	ž	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town o	r Location					10d.	Inside City Limits
he Meryl	sa-f short ormed a	Maryland Worceste	r	Berlin							1 Yes XXNo
ath with ti	r items 23s or 28s-fs riner must be nortised Funeral Director	9031 Stephen Deca	itur Highw		21	B11			U.S.A.		
Naryland 21215-0020 2 should be filed within 72 hours after death with the Meryland and Mental Hygiene.	Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examines must be notified at once.  To Be Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 Yes No If Yes, Give Yeer or Detes:	ver in U,S.	13. Was Dece If Yes, spe 1 ☐ Yes		Hispenic Origin? (Spen, Mexican, Puert	pecify Yes or No o Rican, etc.)	Biad	e - American ck, White, etc :: Whit	
5-0 72 h	natu gical	15. Decedent's Edu (Specify only highest grad		16a. D	ecedent's Usu Sive kind of wo	ai Occu	pation during most of wor ed)	king	16b. Kind of B	usinass/Indus	try
12.1 iff in .	un du	Elementary/Secondary (0-12)	Coilege (1-4or 5+)	)		se retire	ed)		Law Fa	£	
tygied 2	CO	17 Fetheric Name (First Middle ( cet)		Pol	iceman		10 Methor's Non	no /First Middle	Law En		ent
Dance fill be fill	B S	17. Father's Name (First, Middle, Last)	C							10)	
L Me	To To	Ebe Burton Elliott  19a. Informant'a Name/Relationship (Ty		105.1	In Ilina Addrson	n /Ctua a	Eunice I			State Zie Co	ada)
Maryiand of 2 should be file the end Mental Hy	Taur	Sallie Tilghman Eli					Decatur				21811
1 end Heelth	the car	20a. Method of Disposition	noce	20b. Place of D	isposition (Na	me of		Date	20c. Location -		
Baltimore, semit. Pages 1 er	0 0	1 ☐ Buriai 2 To Cremation 3 ☐ F			crematory or						
Itin	rtant njun	4 Donation '5 Other (Specify) 21. Signature of Funeral Service License		Cape F			rematory	1/18/9	9 Fran 8 William	C+	DE
<b>Ва</b> Реги	any Ir	V M. Sich	Bula	L			Funeral H	Income and	Berlin,		21811
		23a. Party Enter the disease, or compi	licetions thet causet .li ne cause on each li e	he death. Do not	enter the mo	de of dy	ing, such as cardiac	or respiratory	arrest,	In	pproximate tervai Between
/Me	ician edical miner	Immediate Cause (Final disease or condition resulting in daath)		estive			Felen	l			nset and Death
<u> </u>	nsit miner		b								
50,	physician and is the bunel-trensit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	D.	ua to (or as a cor	nsequanca of)						
£ 5	E	that initiated avants resulting in death) Last		ue to (or as a cor	sequenca of)						
BOX	d by the ettendi eteched for use Physician/		d							1	
	the hed f	Part II. Other significant conditions cor	ntributing to death but	not resulting In th	ne underlying	cause g	iven in Part I.	23b. Did	l tobacco usa co	ntribute to th	ne cause of death?
S, P.O.	gned by be detect by Phy	Chronic of	bstrutul	pul	morre	4	asen	1)8	Yas 2□ No	3 Probat	bly 4 Unknown
0 0	2 should			,		,			s an eutopsy formed?	availa	autopsy findings able prior to lietion of cause ath?
m g	is certificate he director, page							10	Yes 20 No	1 🗆 Y	res 2□ No
/ita	rector, par rector, par Be Co	25. Was casa referred to medicat examinar?					26. Place of Dea	ath (Check only	one)		
DIVISION Of VITAL or Attending Physician: offer death.	merel dire	1 ☐ Yes 2 ☑ No  27. Manner of Death D⊠Natural 5 ☐ Pending	Hospital: 1 ☐ Inpatiant 28a. Data of Injury (Month, Day)		ne of	OA O			how injury occur		
SIO Pendi	the fi	2 Accidant invastigation 3 Suicide 6 Could not be			М		]Yas 2□No				
DIVI	al Director: After t led in by the funera Certification:	4 Homicida datemined	28e. Placa of injury building, etc.		, straet, factor	y, office		28f. Location City or To	(Street and Numb own, State)	oer or Rural R	loufe Number,
DIVISION Of To the Hospital or Attending Phys within 24 hours effer death.	To the Funeral Director: After the completely filled in by the funeral Medical Certification:	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examination	sician: To the best of nar: On the basis of e and manner state	xamination and/d	aath occurred or investigation	at tha t	ima, data and piace opinion, daath occu	, and dua to the rred at the time	a causa(s) and ma , data and piaca,	anner as state and due to th	ed. e causa(s)
To the	Me	29b. Signeture end title of certifier	2/2		29	c. Licen	ise number		29d. Date signe	d (Month, Da	y, Year)
r- 51	- 0	1	-			4/11	1283		7/181	49	
		30. Name and address of person who co	ompieted cause of dea	ath (Item 23a) (Tu					/110/	//	
	N	ROBERT J. DURKI			AMNWA	4 7	DR BERLIN	DN ND			
	State	31. Date filed (Month, Day, Year)	32. Registrar		1	1.					
В	State Registrar		399	spec 1	9. 1	DO	No.1				

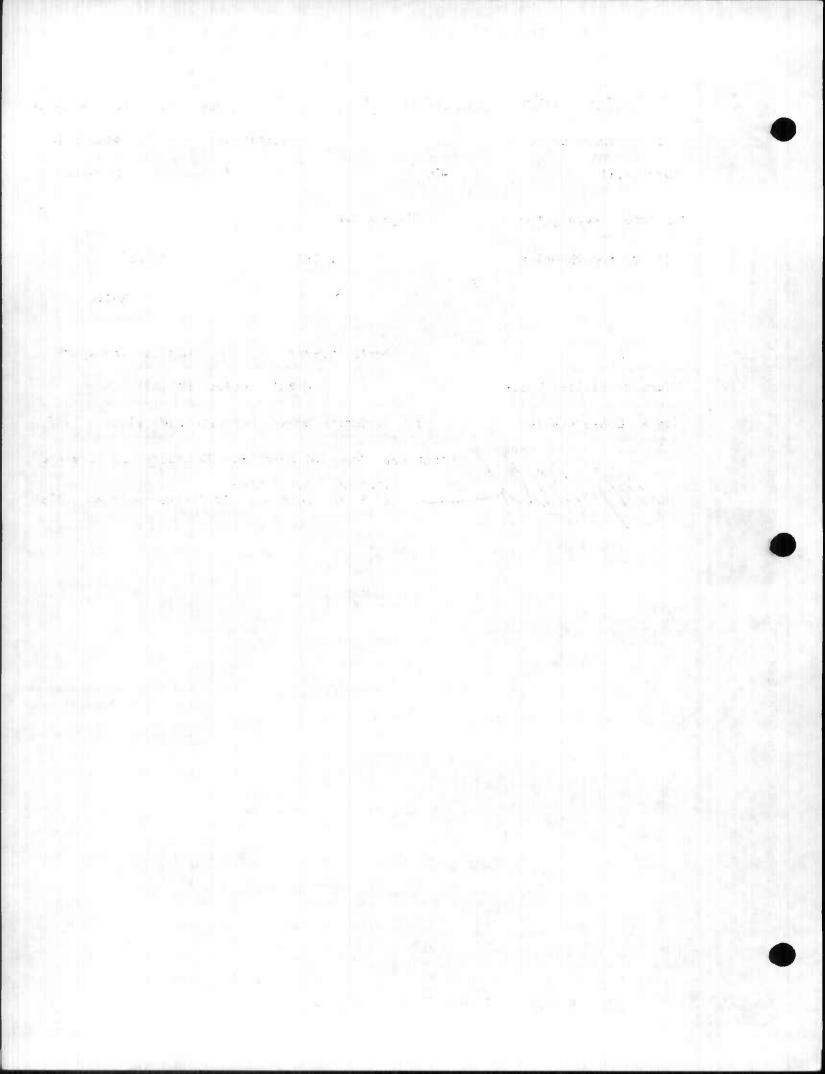
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State of Maryland / Department of Health and Mental Hygiene 99 24052

								Certif	ficate	of l	Death			Reg. No	).		
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ķ.	Examin	er				iliber)					-				County of		
			119 Dartmouth	Driv	e								town				hington
	Funeral		5. Social Security Number	6. Sex		7. Aga (In	yrs. last birt		Undar 1 Y	aar_ ays	If Undar Hours	24 Hrs. Min.	8. Data of Bir (Month, Da	th v. Year	) 5	9. Birthpl	eca (Stata or Foraigi try)
	Director		216-54-7911	11/2	M 2□F		49	Yrs.		-,-			July 30		49		ýland
	27		Usual Residence of Decedant	-													
	ye m		10e. Stata 10b. County	,		10c	. City, Town	or Locat	ion							10	Od. Insida City Limits
	Many 4 eh	ō	Maryland Wash	inat	On		Н	lager	stowr	1							1 Yas 2XXNo
	P 88 9	8	10e, Street and Number	i iig i	011		•		10f. Zip Co					10a C	tizen of Wh	ot Coun	ln/2
	5 6	Director	Toe. Street and Number						TOI. ZIP CC	NJ81				Tog. Ci	(1281) 01 111	iai Couri	uyr
	5 23 E	8	119 Dartmouth	Dri	ve						742				US	A	
	90 E	Funeral	11. Marital Status		12. Was Dace Armed Fo		In U,S.	13. Was	Decedan	t of H	ispanic Ori	gin? (Sp	ecify Yas or No Rican, atc.)	-	14. Race	- Amarica Whita, a	
0	of the part of the	리	1 ☐ Navar Married 2 💢 Ma	ried	1 🗌 Yas	2 NO			Yas 2	,		i, i daito	Tiloati, ato.)				
21215-0020	n 72 hours efter death with the Maryland "naturel", or frems 23s or 28s-f show solical Examiner must be notified at	2	3 ☐ Widowed 4 ☐ Divorce	1	If Yas, Giv Yaar or D	va atas:		10	Yas 21	ONA	Specify:				Specify:	Whit	e
5	thur thur	8	15. Deceda	nt'a Edu	cation		16a.	Decedan	t's Usual C	)ccup	ation			16b. F	(Ind of Busi	iness/Ind	lustry
0	n 7	Completed	(Specify only highs	st grade	complated)			(Giva kin	d of work of NOT usa	dona e	during mos	t of work	ing				
V	yethin plene. r than "	E	Elementery/Secondary (0-12)		Collaga (	1-4or 5+)	1				•			Mad	1001	T	
N	e filed other other vent, u	ပိ	12	4				Ad	minis	STE		4. 11	e (First, Middle				sport
Maryland	0 = 0 >	Be	17. Fathar's Nama (First, Middla								18. Mothe					,	
Z Z		2	Clarence Willi	am (	ossaro	d					Haze	1	ouise.	Me I	lott		
9	S DE E		19e. Informant's Name/Ralation	ship (Ty	pe, Print)		19b.	Malling A	Address (S	treet	and Numbe	er or Rur	al Routa Numb	er, City	or Town, S	tete, Zip	Code)
Ξ	alth a	-	Tina M. Gossard	/Wii	6		11	Q Da	rtmo	ith	Driv	e	lagersto	wn.	Maryl	and	21742
a)	1 end 2 Heelth em 27 i		20a. Mathod of Disposition	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		20	b. Place of cemater					T	Data		ocation - C		
saitimore,			1 ₺ Burial 2 □ Cramation	3 □R	amoval from	State											
	permit. Peges 1 end Department of Heelit Important: If item 27 eny injury or other t		4 □ Donation 5 □ Other (3	10.0	A		edar	Lawn	Memo	pri	al Pa	rk 7	-15-99	Hag	ersto	wn,N	laryland
0	Depart mport mport any in		21. Signatura of School Service	(hijh	411 1			22. N	ama and A	Addra	ss of Facili	у Ц	mo				
0	88 = 8		1///4/	11.1	11												D 21705
		-	23a. Part1. Entar ma disaasa, d	r compli	cations that o	rausad tha	death Dor	4ZD	be mode o	on f dvin	OCOCII	cardiac	e St.W	rrest	amspo	1,1	Approximata
			shock, or heart feilura. Lis	only or	e causa on a	ach lina.	dadii. Doi	rot arritar t	na moda c	n Oyn	ig, 5001 as	Cardiac	or respirotory a	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			Interval Batween Onset and Death
	Physician				-												1 /
2	/Medical		Immediata Causa (Final disaasa or condition		EN	00	PATT2	CF F	REN	14	DI	(F1	185			1	14 4 ENG
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	eeth certificate be executed attending physicien and I for use es the bunel-transit	Examiner		C 1		Due Due	10 /07 00 0	+100	146								
	and all	×	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying													1	
68/60,	be ed icien	8	Cause (Diseasa or Injury		61	OMI	3 RU	LOK	E PH	-121	TIC						
à	ertificate be executed sing physicien and se es the buriel-transit	edical	that initiated events rasulting in daath) Last			Dua 1	to (or as a c	onsequar	nce of):							İ	
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000	th ce	an			J											İ	
	0 0 2	Physician	Part II. Other significant conditi	ons con	tributing to de	eath but not	resulting in	the unde	riying cau	sa giv	an In Part i		23b. Did	tobacc	o uss cont	ributs to	the cause of death
5	requires that the di een signed by the hould be detached	μŽ			-		00 10		1,000				10	Vee	2□ No ;	3 □ Prof	pably 4 Unknow
7	that ded det		FATTENT STUPE	13/	FHOE	X46x	(1)	7 2.	27						20110		,
Records,		d by											24e. Wes	an out	one.	24h Wa	ara autopsy findings
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ō	ficel or, p	0	25. Was case referred to medica	M.							OC Dise	at Deat	h (Ohaali anh	anal .			2011
Vital	Physician: The	OB	axaminar?		lospital:					Oth	0.5		h (Check only				
5	2 00	-	1 ☐ Yas 2 ☐ No		10		2 ER/Ou		3 DOA		4 U N	irsing Ho			6 Other		y)
	After funer	5	27. Mangar of Death 1 Watural 5 □ Pandi	na	28a. Date (Mon	of Injury th, Day Yes		Time of njury	28c	. Injur Wor	y at k?		28d. Describe	now inj	ury occurre	a	
Division	Attending or deeth. ector: After by the fune	at	2 Accident invast	igation					M	1 🗆	Yes 2	No					
<u>"</u>	Att de by t	Ĕ	3 ☐ Suicida 6 ☐ Could 4 ☐ Homicide detari		28a. Place	of Injury -	At homa, fa	rm, streat	, factory, o	ffice			28f. Location ( City or To			r or Rura	l Routa Number,
5	of attendent effer deeth Director: /	Certification:	4 C Tromodo		Dulla	ing, arc. (o)	/GCHY)						ony or ro	, 0,0	,		
	Phre ours		29e. Certifier 1□ Certifyi	na Phys	ician: To the	best of my	knowledge	daath or	curred at 1	tha tir	na. data er	d plece.	end due to the	ceuse(	s) and man	nar as si	ated.
	Fur Fur	edicai			er: On the b								red at the time,				
		Š	29b. Signature and title of certific	v	and man	310160.			200 1	icene	a number			29d D	ata signed	(Month	Day Yearl
	5 3 E 8	-	1 15	_		-	<i>i</i> ^		1 LOU. L					~	/1 00	governmentery.	
			1775 his	_		>	(71)		1	13	712	)		1.	12 47		
		1	30. Nama and address of persor	who co	mpleted caus	se of deeth	(Item 23a) (	Type, Pri	nt)	_=							
			OTTO ROZA	fil	100	1 - 0	AK 411		1 /	A/-	ERST	Lu.	HA. 2	17	42		
			0 11 (1000)	)	32 F	ogistrar's S	-	1	10	,,0	17 - O/C	,		2 2			
	Stat Registra		31. Data filed (Month Day Year	199	9 /	12 park	/	g.	don	1	1						
	riegistic					7	/		1								



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month 0142 Junnita Grimm Virginia 10/4 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Hospital Hagerstown mashington County Washington If Under 1 Yeer | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In yrs. lest birthday) Days 1□ M 2⊠ F Months Yrs. JAN. 29, 1928 WEST VIRGINIA 236-40-7836 71 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No WASHINGTON MARYLAND HAGERSTOWN 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A.

14. Raca - American Indian,
Black, White, etc. 11311 LAKESIDE DRIVE 21740 Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, apecify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 □ Divorced Year or Dates: WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 6 HOMEMAKER OWN HOME 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) RAYMOND HENRY FRAZIER SR. MELLIE BLANCHE HAINES 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA A. SHANK/DAUGHTER 185 FRONT DRIVE, WINCHESTER, VIRGINIA 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 5 Other (Specify) 4 Donation 7/22/99 CEDAR LAWN MEM. PARK HAGERSTOWN, MARYLAND yurn of Puneral Service Licer 22. Name end Address of Facility 7606 Old National Pike BAST FUNERAL HOME Paul M. Dean Boonsboro, Maryland 21713 23a. Pert 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Finel Sepsis few days disease or condition resulting in deeth) Due to (or as a consequenca of): Catheter infection Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Hyperalimentation dependence Physician/Medical Due to (or as a consequence of): Fistulas enterocutaneous Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Stroid dependent chronic obstructive 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed Natritional depletion - Obesity - Hypertension completion of cause of death? - Ventral Fascial defect - Deplession 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 28. Plece of Death (Check only one) Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Yes 2 No 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and placa, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29c. License number 20 1999 D4608 medical doctor 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Frank J Collins 340 mill street Hagerstown md 21740

State Registrar

**Physician** 

/Medical

Examiner

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Certification:

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**Funeral** 

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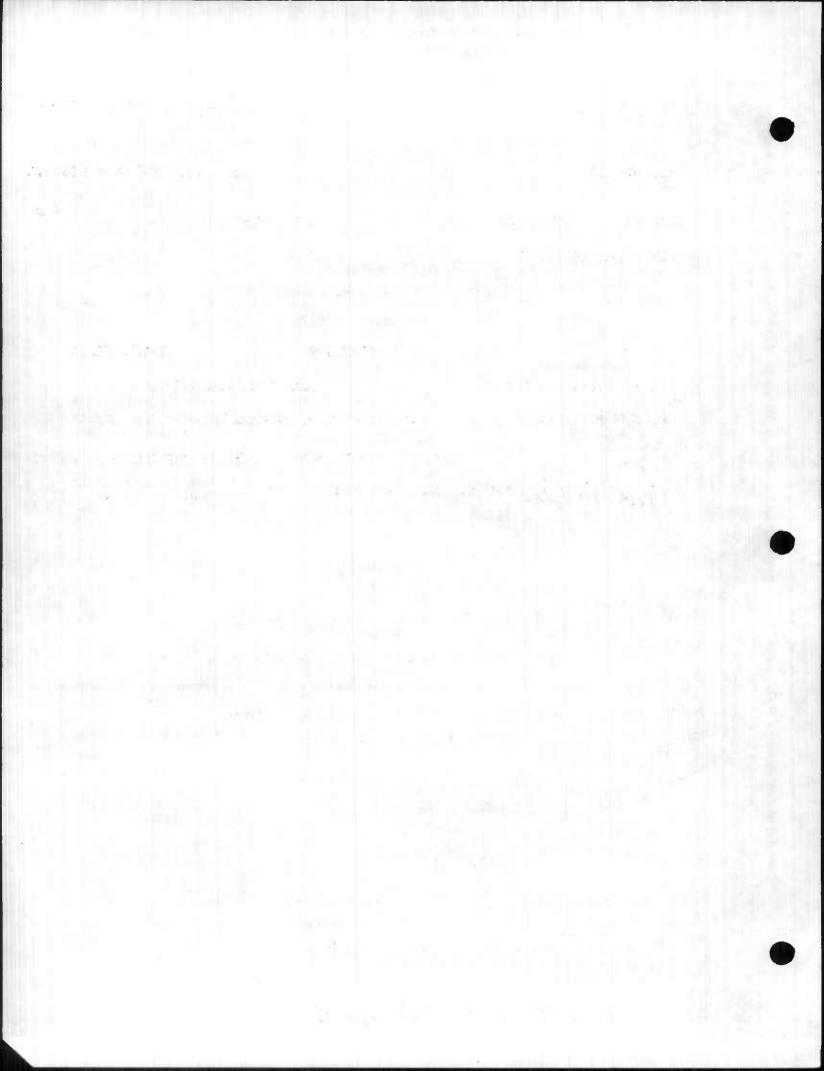
Division of Vital

Baltimore, Maryland 21215-0020

31. Dete tiled (Month, Dey, Year)

2 1 1999

32. Registrer's Signature



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 3. Time of Death 1 Decedent's Name (First Middle Lest) 2. Date of Death **Physician** Genevieve Lena Gamby 0000 July 8 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner Washington County Hospital Hagerstown Washington If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) If Under 1 Yaar 5. Social Sacurity Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 XF Months Days 89 Yrs. 189-07-8607 Jan. 11, 1910 Penna. **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health end Mental Hygiena. Important: If Item 27 is marked other than "natural", or ferms 23a or 28a-4 show any Injury or other traumstic event, the Medical Examination Engineer. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Md. Washington Boonsboro Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8507 Mapleville Rd. 21713 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Ricen, etc.) 14. Race - Amarican Indian. Black, White, etc. 1 Navar Marriad 2 Married Specify: White 1 ☐ Yes 2 XNo Specify þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Garment Mfg. 18. Mother's Name (First, Middle, Malden Sumame) 17. Father's Name (First, Middle, Last) Newton Isaac Bingaman Emma Lucetta Kessler 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Larry R. Gamby/Son 9937 White Hall Rd. Hagerstown, Md. 21740 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriai 2 ☐ Cremation 3 ☐ Ramoval from State Parklawns Memorial Gardens 7/12/99 Chambersburg, Pa. 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Facility 21. Signature of Funeral Service Licenses Zimmerman And Son Funeral Home Inc. 45 S. Carlisle St. Greencastle, Pa. 17225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onsat and Death **Physician** Immediata Cause (Final disease or condition rasulting in death) /Medical · Cerebrovascular Accident /day **Examiner** Due to (or as a consequence of) Physician/Medical Examiner ettending physicien and for use as the burial-transit The law requires that the deeth certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initieted events resulting In death) Last Due to (or es a consequence of) Division of Vitai Records, P.O. Box 68760, Due to (or es a consequence of): signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse givan in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Dementia, Osteoporosis, Respiratory Failure Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy and Carbon Dioxide Retention, Urinary Tract completion of ceuse of death? In Fection 1 Yes 2 No 1 ☐ Yas 2 ☐ No certificata or Attending Physician: after deeth. 25. Was case referred to medical axaminer?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA in 24 hours after deeth.

the Funeral Director: After this appletely filled in by the funeral di 28e. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 DNatural 5 Pending 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) To the Pwithin 2
To the F 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D47451 July 08, 1999 cyntria Kutine, - Sando, mo 30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print) Cynthia Kuthner-Sands, MD 11110 Medical Campus Road Haperstown, Maryland

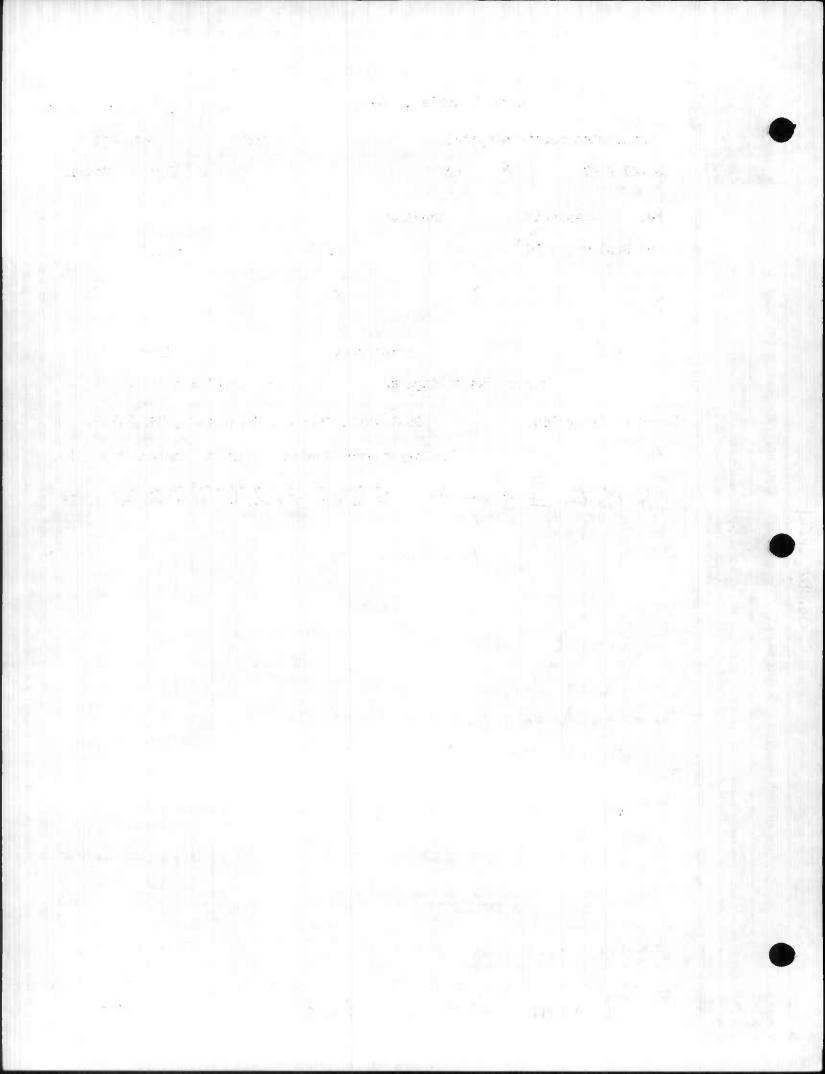
State Registrar 31. Date filed (Month, Day, Year)

JUL 0 9 1999

32. Registrar's Signature

21742

Bamby, Leng



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Charles Axley Graham JUL 14,1999 /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll County General Hospital Carrol1 Westminster 8. Dete of Birth (Month, Dey, Year) Feb. 1, 1916 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country) Virginia Days 1⊠M 2□ F 83 Months Hours 226-18-6373 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 No Yes 2 No Directo Maryland Carroll New Windsor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? flams 23a or 302 College Ave. 21776 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Bleck, White, etc. 11. Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Merried "natural", or 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) automobile service Elementary/Secondary (0-12) College (1-4or 5+) mechanic center 6 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) 89 h and Mental John Ranson Graham Bertha Anderson 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Item 27 i Ora A. Graham/ wife 302 College Ave. New Windsor, MD 21776 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 8 Department of Important: If It 1 Burial 2 Cremetion 3 Removel from State 7/17/99 Westminster, MD Meadow Branch Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility Hartzler Funeral Home 21. Signature of Funeral Service Licens 310 Church St. New Windsor, MD 21776 23a. Pert1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart fellure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** SPASIS Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner MYOCANDIAL INFAMERON ettending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 7BAILLATION à 24b. Were autopsy findings aveilable prior to completion of cause of death? Be Completed 24a. Wes an autopsy performed? 1 Yes 2 No 1 Yas 2 No 25. Was case referred to finedical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To **≯** Inpatient 2 ER/Outpatient 3 DOA After this 28c. Injury et Work? 27. Manger of Death 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 5 Pending investigation Netural 1 ☐ Yes 2 ☐ No 2 Accident erel Director: / 6 Could not be 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours a To the Funeral D completely filled I Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signeture and title of certifie License numbar 29d. Dete signed (Month, Day, Year) 221 200 Memorial Avenue Westminster, MD COUNT (BEEDER ANNOUC 31. Dete tiled (Month, Day, Year) 32. Registrar's Signature State Registrar

**DHMH 16 Rav 6/95** 

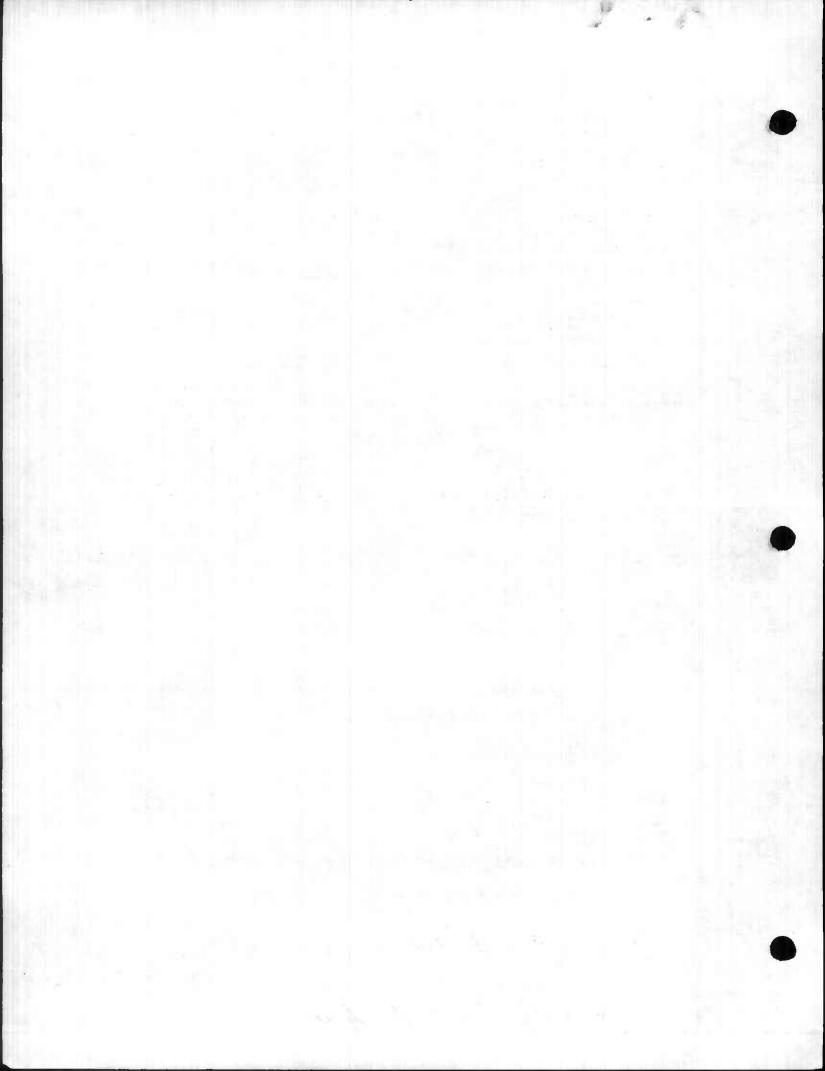
Box 68760,

P.O.

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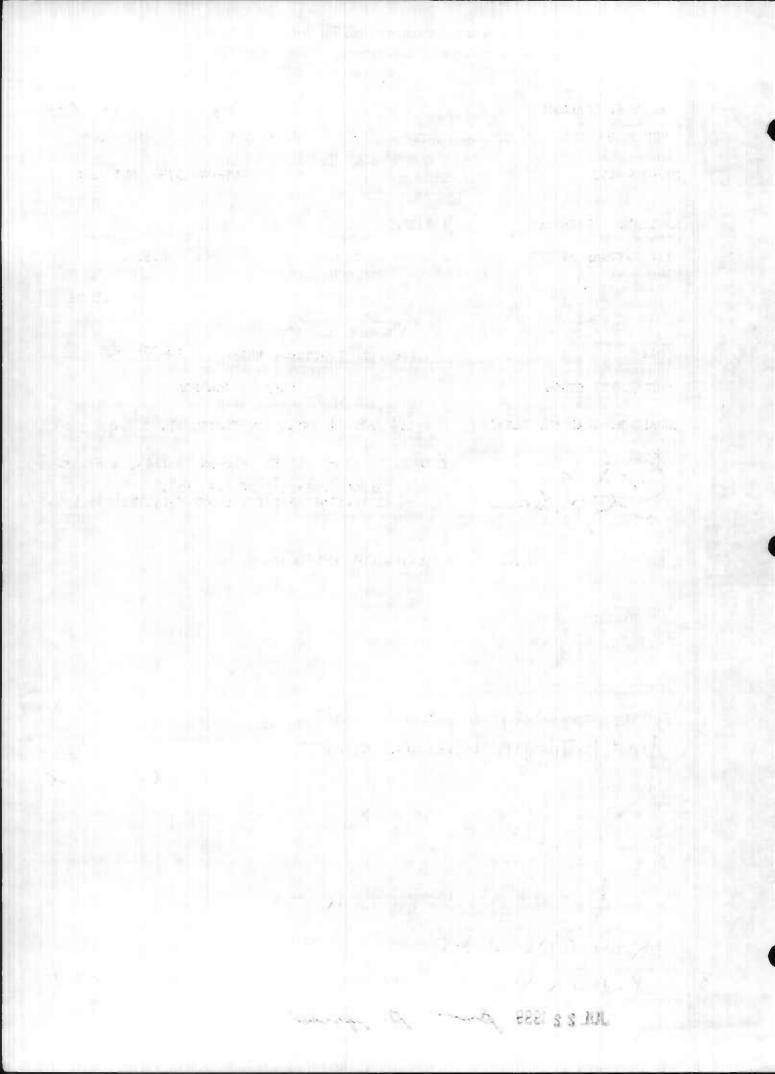
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217-30-8393

GHUDEN

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3 Time of Death **Physician** July 24 1999 Adeline B. Garrett 11:20 PM /Medical 4a. Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Herman Wilson Health Care Center Montgomery Gaithersburg If Undar 1 Year | If Undar 24 Hrs. | 8. Dete of Birth (Month, Day, Year) | Feb. 3, 1912 5. Social Security Number 9. Birthplace (State or Foreign Country) Maryland 7. Aga (In yrs. last birthday) **Funeral** 1□ M 2XF 220-44-9462 Vrs 87 Director Usual Rasidance of Dacedant the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits raf', or items 23a or 28a-f show Examiner must be notified at Gaithersburg 1 Yes 2 No MD Montgomery Director 10e. Street end Number 10f. Zip Coda 10g. Citizen of What Country? with 20877 U.S.A. 301 Russell Ave. death Funeral 12. Wes Decedant Evar in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. pemit. Pages 1 and 2 should be filed within 72 hours after d Department of Haelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or item eny injury or other traumatic event, the Medical Essenti 1 Nevar Married 2 Merried 1 ☐ Yes 2 ☒ No If Yas, Giva Yeer or Detas: Baltimore, Maryland 21215-0020 1 ☐ Yas 2 X No Specify: White þ 3 X Widowed 4 □ Divorced Completed 15. Decedant's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use ratired) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) Homemaker Domestic 12 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Surnama) Be Unknown Unknown 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 640 S. Pine St., Arlington Heights, IL 60005 Dawes Garrett/Son Yorktowne Caskets, Inc. July 27, Cremation Service 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 MCremetion 3 🗷 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) York, PA 17404 22. Nama and Addrass of Facility J.J. Hartenstein Mortuary, PA 17349 24 Second St., New Freedom, that susad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximeta intarvai Between Onset end Death Physician Immediata Causa (Final diseasa or condition rasulting in daath) /Medical Neay Consistave Examine Dua to (or as a consequence of): Physician/Medical Examiner Due to (or es e conseduance of): The law requires that the death certificate be executed attending physician and for usa as the burial-transit Sequentielly list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disaase or Injury that initiated evants racuiting in daath) Last Division of Vital Records, P.O. Box 68760, Dua to (or as a consequence of) signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown homo chromatosis þ 24b. Wara autopsy findings available prior to completion of cause of daath? been si 24a. Was an autopsy performed? Completed certificate has b 1 Yas 2 110 1 ☐ Yas 2 ☐ No or Attending Physician: 25. Was casa rafarred to medical axaminar? Be 28. Placa of Death (Check only ona) To Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No this funeral 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred Certification: Aftar 5 Pending Invastigation 1-MNaturel after death. 1 Yas 2 No 2 Accidant 6 Could not be datarmined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) filled in by 4 Homicida 24 hours a Funeral edical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Cartifie To the Hosp within 24 hor To the Fune complately fi (Check only one) 29b. Signatur and title of certifie 29c. Licansa number 29d. Data signed (Month, Day, Year) MD addrass of person who completed cause of death (Itam 23a) (Type, Print) 6AITHERSBURG, Md. 20879 MELNICH 911 Ruisell

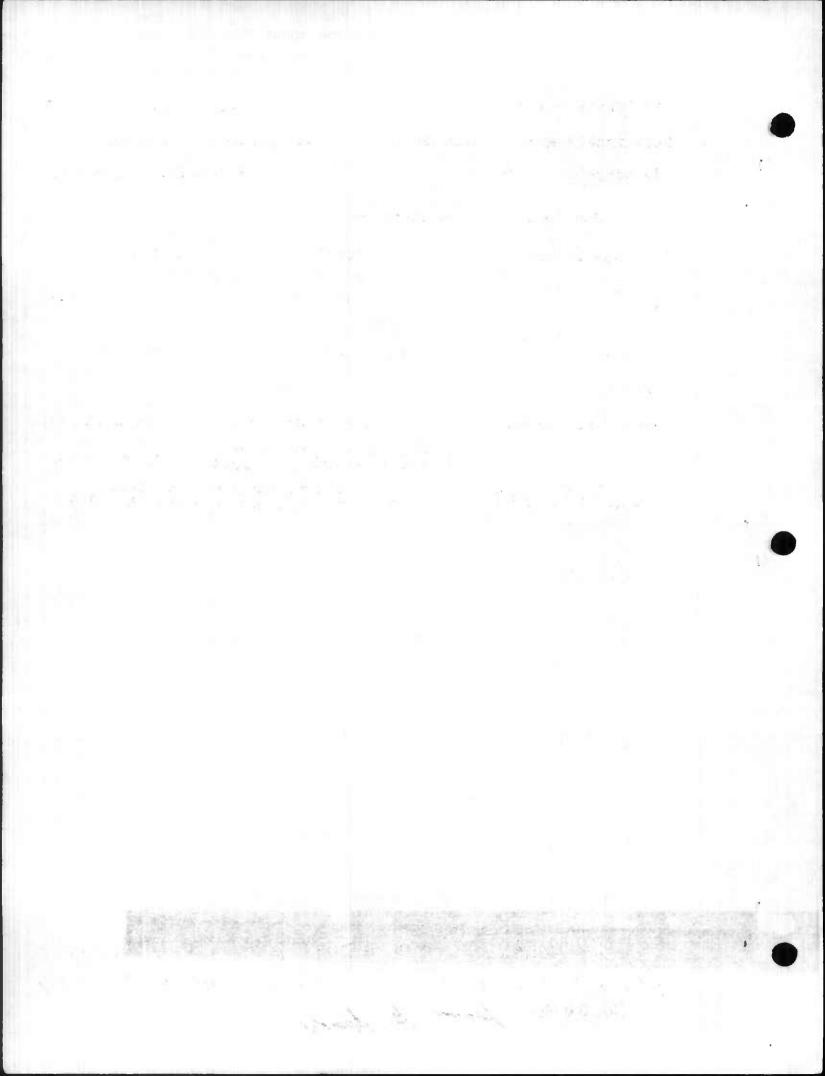
32. Ragistrar's Signatura

Spark

1999

State Registrar 31. Date filed (Mo

**DHMH 16 Rev 6/95** 



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month unalc lan 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Neme (If not institution, give street end number) P.G. Clinton Southern Maryland Hospital If Under 24 Hrs. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month Dev. Year) 34 9. Birthplece (State or Foreign 1∏M 2□ F Months Days Hours Scranton, PA 64 578 52 2713 Usuel Residence of Deceden 10b. County 10c. City, Town or Location 10d. Inside City Limits Brandywine P.G. 1 ☐ Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? United States 20613 8411 Boundry Lane 12. Was Decedent Ever in U.S. Armed Forces? XXYes 2 \( \text{No.} \) No. 1952 If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. 1 □ Never Merried 2 □ Married 1□Yes 2□No Specify: Specify: White 3 ☐ Widowed 4 ☑ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Allegany Airways Ramp Supervisor 10 18. Mother's Neme (First, Middle, Maiden Sumeme) Mary Virginia Doyle George Franices Gould 19a. Informent's Name/Reletionship (Type, Print)

15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) 17. Fether's Neme (First, Middle, Last)

Julia Ann DuShane (PER REP)

1 Buriel 2 Scremetion 3 Removel from State 4 Donetion 5 Other (Specify)

19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 1785 Harrison Street Unit 709, Tutusville, FL 32780 Date 20c. Location - City or Town, Stete

20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Lee Crematory July 17,1999

22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735

P. 1. Enter the diseese, or shock, or heert failure. Li compligations to a cause the deeth. Do not enter the mode of dyling, such as cardiac or respiratory errest, tmmediate Ceuse (Finel

Approximete Intervat Between Onset and Death

disease or condition resulting in deeth)

20e. Method of Disposition

21. Signeture of Furierel Service Libensee

**Physician** 

/Medical

Examiner

10e. Stefe

Directo

Funeral

by

Completed

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Examiner

Physician/Medical

by

Completed

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Certification:

Medical

MD

**Funeral** 

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be noticed at

permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23 any injury or other traumetic avent, the Medical Example must

**Physician** /Medical

Examiner

sician and burial-transit

attending physician for use as the buria

Box 68760

P.O.

Records,

Division of Vital

i or Attending P. efter death.

Hospital
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 Funeral C

To the To the To the

Baltimore, Maryland 21215-0020

the Marylend

Due to (or as a consequence of):

1 WKS

Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lasf

NFECTED BILATERAL BELOW-THE ENEE STUMPS

Due to (or es e consequence of): METHYCILIN-RESISTANT-STAPHYLOCCOCUS-AUDEUS INFECTION Due to (or es e consequença of)

Ô

Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco uea contributa to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown

END-STAGE RENAL DISEASE

INSULIN -DEPENDENT DIABETES MELLITUS

24a. Wes en autopsy performed?

Clinton, Maryland

24b. Were autopsy findings svailable prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 1 Yes 2 No

07/16/99

25. Wes case referred to medical exeminer? 28. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Ves 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

Dete of tnjury (Month, Dey Year) 28c. tnjury et Work? 27. Menner of Deeth 28d. Describe how injury occurred 1 Naturet 5 Pending investigation 1 ☐ Yes 2 ☐ No

2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide

12 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the ceuse(s) end menner es stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner stated. 29e. Certifier

29b. Signeture and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year)

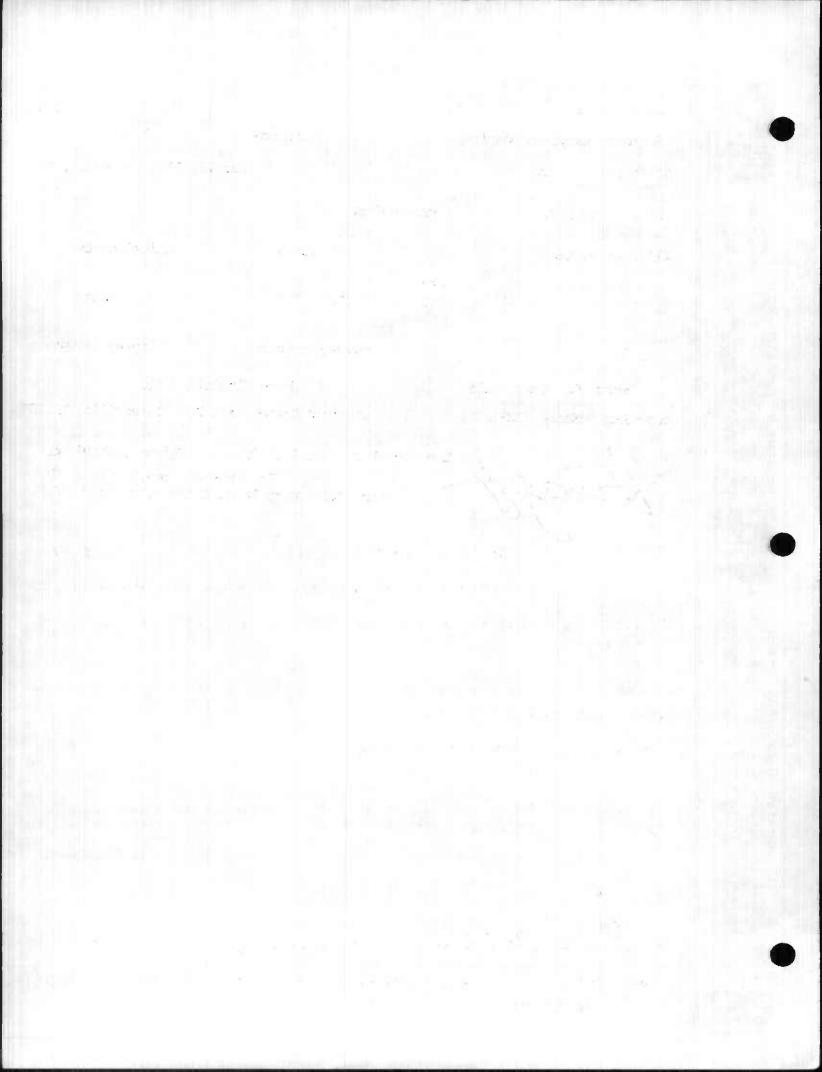
D-15(13(MD) 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

LUCIO S. VILLA-REAL, M.D., - #10 ST. PSTRICK'S DRIVE, SUITE 502, WALDORF, MO 20603

31. Date filed (Month, Day Year) 2 1 1999 32. Registrar's Signeture

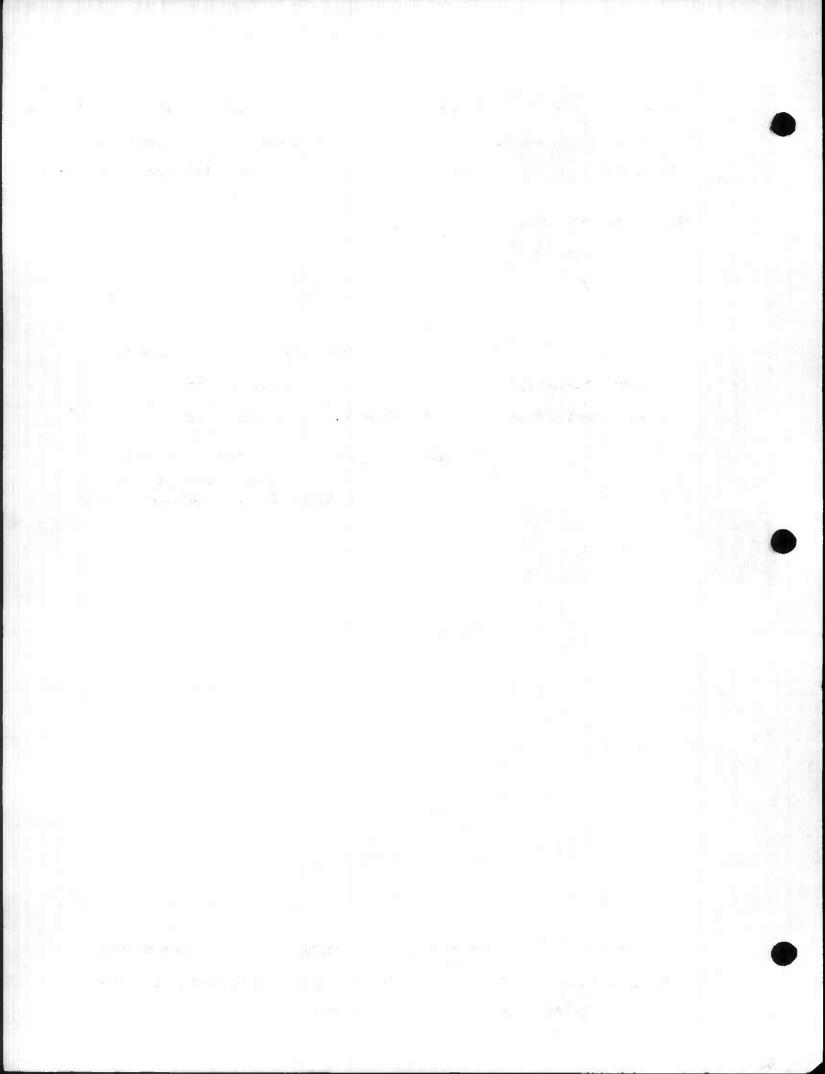
State Registrar

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# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of Mi	aryland		Sertifica		Death	мена пу	giene Reg. No.	9 2	4059	
	D1	7	1. Decedent's Name (First, Middle, La	st)						2. Data of De		Year	3. Time of Death	
	Physici /Medio		Lenora Mae	Но	ffma	n				July 9		rear	11:29 a	ım
	Examir		4e. Facility Neme (If not institution, giv	e street end number)					4b. City, Town, or	Location of Deal	h 4c. Coun	ty of Deeth		
			Washington Co.						Hagerstow	/n	Wash	ingto		
	Funeral Director		-70 28 1007	ax 7. Ag	a (In yrs. Ia 76	st birth	Month	ar 1 Year s Days		8. Date of Bir (Month, Di July 12	th by, Year) 1922	9. Birthp Coun Penns	lace (Stata or Fore try) ylvania	gn
	aryland show	7	Usuel Residence of Decedent  10a. State  10b. County		10c. City,		or Location					1	0d. Inside City Limi	
	N P N	Director	Pennsylvania Armst	rong		D	ayton							
	23a or 2		North Poplar	St			10f. 2	ip Code	16222		10g. Citizen of U.	S.A.	try?	
020	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene.  If item 27 is marked other than "natural", or items 23s or 28s-1 show or other traumatic event, the Medical Examinar must be notified at	by Funeral	11. Marital Stetus  1 Never Merried 2 Married  3 Widowed 4 Divorced	12. Was Decedant Armed Forces? 1  Yas 2 1 Yas Give Year or Dates:					Hispenic Origin? (S sen, Mexican, Puerl Specify:	pecify Yas or No to Rican, atc.)	Speci	ack, White, Wh		
Maryland 21215-0020	vithin 72 ho	Completed	15. Decedent's Ec (Specify only highast gra Elementery/Secondary (0-12) 1 2		i+)	(4	ite. DO NOT	vork dona use retire	during most of wo	rking	16b. Kind of I		lustry	
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an	d be fental I	To Be	Thomas McElh:							Millir		1110/		
Mary	od 2 shou th and M 27 is mari	F	19e. Informant's Neme/Reletionship ( Bauer-Bly Funeral						tend Number or Ru Dayton, I		-	n, State, Zip	Code)	
timore,	permit. Pages 1 and 2 Department of Health s Important: if item 27 is any injury or other tre		20a. Method of Disposition  1 X Burlal 2 Cremation 3  4 Donetion 5 Other (Specification)		Cea	metery,	Olsposition (N cremetory of Cemet	other ple		Deta -13-99	20c. Location		wn, Stete	
Balti	permit. Departminports any inju		21. Signeture of Funeral Service Lican				22. Name	and Addre	ess of Fecility Mir ilson Bly	nnich Fu	neral H	lome	21740	
•	Physician		23a. Part1. Enter the disease, or com shock, or heart feilure. List only	plications thet caused one causa on each lin	the deeth.	Do no							Approximeta intervel Between Onsal and Death	
	/Medical Examiner		Immediate Cause (Final disaasa or condition resulting in deeth)	θ			CC		ascular d	isease			10 yrs.	
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oʻ	ificate be executed physician and as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	b	Due to (or	es a co	nsequence of	):				1		
	T 0 6	/Medical	Cause (Disease or Injury that initieted events resulting in deeth) Lest	d	Due to (or o	9S 8 CO	nsequence of	):						
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P.0.	res that the de igned by the a be detached f	Physician/M	Pert II. Other significant conditions of	ontributing to death be	at not resul	ling in t	ne underlying	cause gi	ven in Pert I.		Yes 2 No		the cause of deat bably 4 Unknown	
Division of Vital Records,	been should	Completed by									an autopsy ormed?	ava	ere autopsy linding allable prior to appletion of cause death?	8
ř	The page	E O								1 🗆	Yes 2 No	10	Yes 2□ No	
<u>Ta</u>	ysician: The is certificate director, par	Be	25. Wes case raferred to medical examiner?						26. Place of Dec	eth (Check only	one)			
on of v	offing Phys h. After this funeral di	2	1 X Yas 2 No  27. Menner of Deeth 1 X Natural 5 □ Pending	Hospitel: 1 ☐ Inpatia 28a. Dete of Inju (Month, De)	у 2	R/Outp 28b. Tin Inji	ne of	28c. Inju		loma 5 ☐ Rasi 28d. Describe	dance 6 On how injury occu		()	
Divisi	al or Attending Is after death. I Director: After of in by the fune	Certification:	2 Accident invasligation 3 Sulcida 6 Could not be 4 Homicide determined		ury - At hon (Specify)	ne, ferm				281. Location ( City or To	Street end Num wn, Stete)	ber or Rura	l Route Number,	
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edicai (		ysician: To the best of niner: On the basis of and menner ste	examinetic									
	To the company	Σ	29b. Signeture and litie of certifier	.0-			2	9c. Lican	sa number		29d. Data sign	ed (Month,	Day, Year)	
			Collected!	W. SiAK	ac			DO	1062		July 9	, 1999	)	
			30. Neme and address of person who a Edward W. Ditto,					ingt	on St. H	agersto	wn, MD	21740	)	
	Sta Registr		31. Date liled (Month, Dey, Year)  JUL 1 3 1999	32 Registre	er's Signetu	re &	So	Bets	1					



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene #5, 18 #8 PER INFORMANT G775 9-1-99 WR. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death ALVERTA HADLEY 145 PM - 1999 4b. City, Town, or Cocation of Death 4e. Fecility Name (If not institution, give street and number) 4c. County of Death 2112 Westfield Avenue Baltimore If Under 24 Hrs. Baltimore If Under 1 Year Birthplace (Stete or Foreign Country) 5 Social Security Number 7. Age (In yrs. last birthday) Days 1 M 35 F 119-14-1736 Woodbine, Pa. Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits MD. **Baltimore** Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2112 Westfield Avenue 21214 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specifi White 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Inspector Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme, David Hadley Alice Wailes WALES 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) Janice Piercy, daughter 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Fairfield Union Cemetery Fairfield, Pa. 21. Signature of Funerel Servica Licenses 22. Name and Address of Facility Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783 art1. Enfer the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heer feilure. List only one ceuse on each line. Approximate Interval Between Onset and Death Cerebral Vescular Dispase Immediate Cause (Final disease or condition resulting in death) Heart disease Stage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initieted events resulting in deeth) Lest Due to (or as a consequence of) Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy tindings evalleble prior to completion of cause of deeth? 24e. Wes en eutopsy performed?

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

**Director** 

Herns 23a or 28a-f show iner must be notified at

death

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if Item 27 is merked other than "naturel", or then eny Injury or other traumetic success.

Maryland 21215-0020

Baltimore,

Director

Funeral

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Completed

Be

Examiner Physician/Medical þ Completed Be Certification: To To the Hospital or Attendiwithin 24 hours effer death.
To the Funeral Director: A completely filled in by the fo

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

							1 ☐ Yes 2 🗹 No	1 🗆 Yes	2 🗆 No				
25. Was case referred to medica		26. Plece of Deeth (Check only one)											
examiner? 1 ☐ Yes 2 ☑ No	Ho	ospital: 1 Inpatient 2 I	ER/Outpatient	3□ 1	Home 5 PResidenca 8 □Other (Specify)								
27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	М	28c. Injury et Work? 1 ☐ Yes	2 🗆 No	28d. Describe how injury occurred	d					
3 Suicide 6 Could 4 Homlcide deter		28e. Place of Injury - At h building, etc. (Special	ome, farm, stree fy)	t, fact	ory, office		28f. Location (Street and Number City or Town, Stete)	or Rural Route	e Num <i>ber</i> ,				

29a. Certifier (Check only one)	1 Certifying Physicia 2 Medical Examiner:	n: To the best of my knowledge, dea On the basis of examination and/or and menner stated.	ath occurred at the time, date and place, and Investigation, in my opinion, deeth occurred a	due to the cause(s) and manner es steted. It the time, date and place, and due to the cause(s
		01		

Attending Physician D53642 July 16 1999

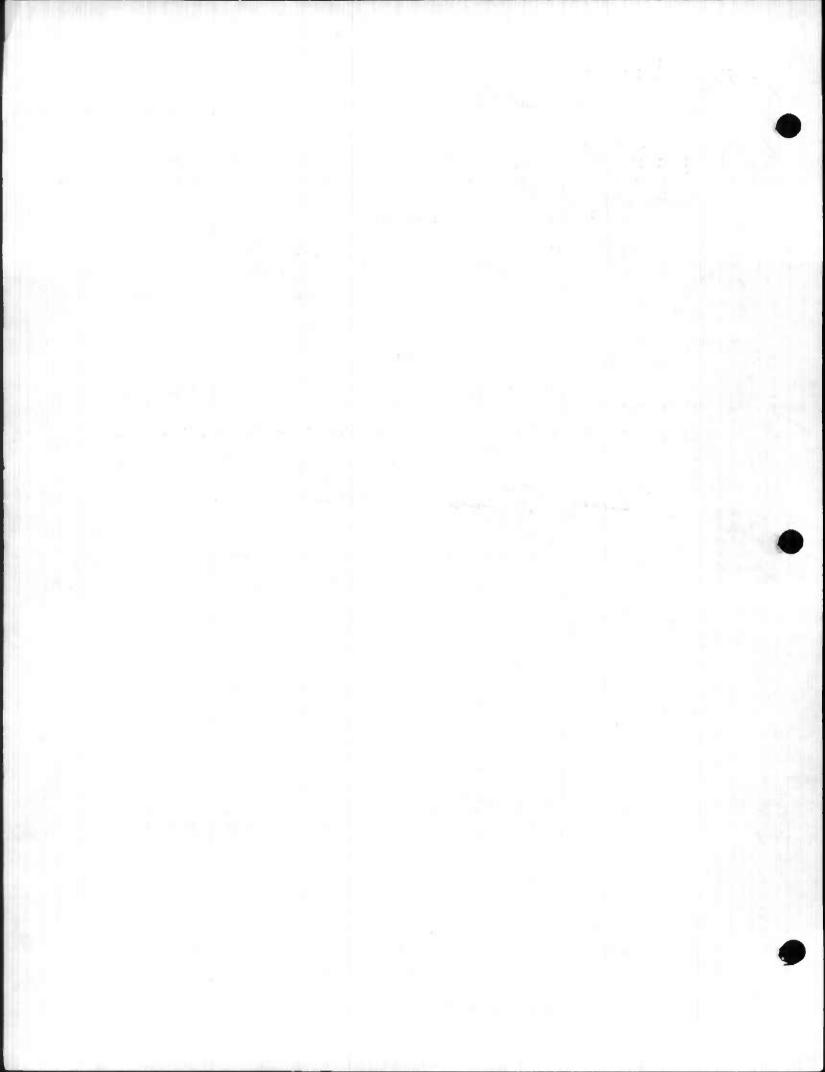
30. Name and address of person who completed cause of death (Item 236) (Type, Print) Northem Park way Baltimore 21214

State Registrar

Medical

31. Dete tiled (Month, Dey, Yeer)





## Please Type or Print In Black Indelibie Ink. Assure All Copies Are Legible.

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leted by Funeral Director	10e. Street and Nu	mber			10f. Zip	Code			10g. Citizen of V	Vhet Country?		-
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Funeral	11. Marital Status	1100111 11	12. Was Decedent I Armed Forces?	Ever in U,S.	13. Was Dece	dent of H	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No		e - American Inc.	dian,	
by	1 ☐ Never Marr 3 ₩idowed	ied 2 Married 4 Divorced	1 ☐ Yes 2 ☑ It if Yes, Give Year or Dates:	90	1 □ Yes		Specify:	o rhour, oro.,	Specify		ite	
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	₩ Burial 2	☐ Cremation 3 ☐	Removal from State	cemet	tery, cremetory or o	other plac	00)					
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	Immediate Cause disease or condition resulting in death)	(Final		tive Due to (or es	heart f	ail				1	months	
Examiner			riyocar		inforat					1 7 0		
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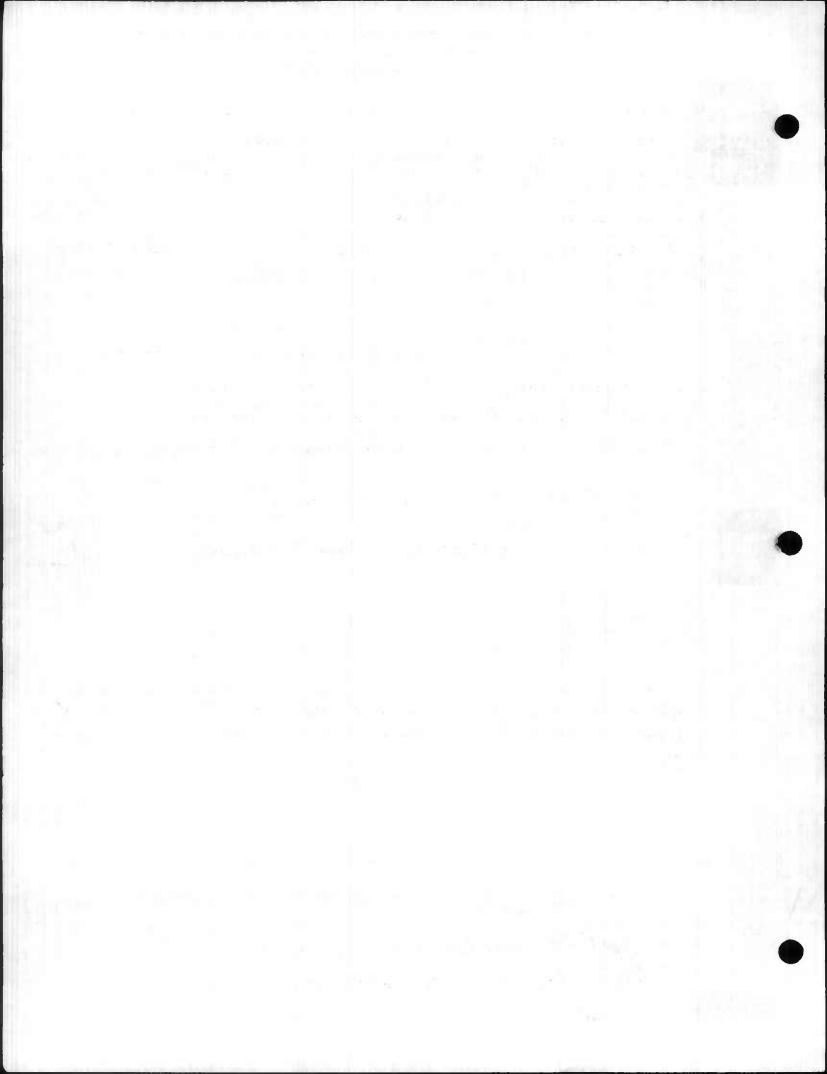
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State of Maryland / Department of Health and Mental Hygiene

						Ce	ertificat	e of	Death			Reg. No.	60" 0	6	. 4 .	106
			1. Decedent's Name (First, Middla, I	.ast)							2. Dete of De	eath			3. Tim	e of Death
	Physic /Medi		MARTHA				нав	RRIS	ION		JULY	Dey 19,1		Yeer Ca	10.	30 a.ı
	Exami		4e. Facility Neme (If not institution, g	ive street and nut	m <i>ber</i> )		nut.			own, or Lo	ocation of Deal		-	of Death	10.	30 a.1
			Calvert Memor	ial Hos	spital	L		P	rince I	reder	rick	Ca	lve	ert		
	Funeral Director		219 10 5149	Sex 1□M 2∏cF	7. Age (In yr. 86	s. last birthday Yrs.	) if Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Data of Bi (Month, Di April	rth ay, Year) 26,		Coun	try)	ata or Foreign
	and *		Usuel Residence of Decedent  10a. Stete 10b. County		10c. C	ity, Town or L	ocation							1/	Od Ineld	e City Limits
	the Maryl 28a-f sho	Director	Maryland Calve	rt		Lusby	7								101	Yes 2 No
	23e or	ral Dir	9710 H.G. Tru	eman Ro	oad		10f. Zip	657				10g. Citize Un		het Count		es
020	72 hours efter death with the Maryland natural, or Itams 23s or 28s-f show sical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3X Widowed 4 Divorced	12. Was Dece Armed Fo 1 Tyes If Yes, Giv Yeer or De	rces? 2 <b>/2</b> No /e	U,S. 13.	Was Deced If Yas, special 1 Yas	city Cub	lispanic Or en, Mexica Specify:	n, Puarto	ecify Yas or No Rican, etc.)		Bieck	- America k, White, a Whi	atc.	1,
21215-0020	C * 0	Completed	15. Decedent's (Specify only highest g	Education rada complated) College (1	-4or 5+)	16e. Dece (Give life.	edent's Usua e kind of wa DO NOT us	el Occup rk dona se retire	etion during mos d)	st of work	ing	16b. Kind	d of Bus	siness/Ind	lustry	
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Baltimore,	8 2 2		20e. Method of Disposition  1 Burlet 2 Cremetion 3 4 Donation 5 Other (Spec		State Mt	Plece of Disp cemetery, cre Hal	osition (Nar ematory or o MON y	ne of checked	mete	¥y <sup>21</sup>	Date 999	20c. Loca Owin	gs.	Cal	m, State Ma:	ryland
Balt	permit. Page Department of important: If any Injury or once.		21. Signeture of Funeral Servica Lice	ansee	`		2. Name er			Rat	ısch F					
			23e. Pert1. Enter the diseese, or co	nplicetions thet co	aused the dec								Keh	Jubi	Approxi	mata
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	Examiner		Immediate Cause (Finel disease or condition resulting in death)  e. CONGESTIVE LIGHT FAILURE  Due to (or es e consequence of):												_	
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	0 0 0	Physician	Pert II. Other significent conditions	contributing to de	eath but not re	sulting In the	underlying c	ause giv	en in Pert i	l.	23b. Did	tobacco u	ee cont	tribute to	the cau	se of death?
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<b>1</b>	00	To	exeminer? 1 ☐ Yes 2 ☒ No	Hospitel: 1XII	npatient 2	ER/Outpatie	nt 3 DC	Oth	er: 4 🗆 Nu	ursing Ho	me 5 Rasi	dance 6	Other	r (Specify	)	
ion of	nding Ph ath. r: After th e funeral		27. Menner of Death 17 Neturel 5 ☐ Pending 2 ☐ Accident investigati	28e. Dete of (Mont)		28b. Time of Injury	of 2	8c. Injur Wor	y et		28d. Describe					
Division	or Atteracted in Director	Certification:	3 ☐ Sulcide 6 ☐ Could not determine	Zoe. Pieca	of Injury - At I	nome, ferm, st	reet, fectory	, offica			28f. Location ( City or To		Number	r or Rural	Routa N	lumber,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifying P (Check only one)  Certifying P  Certifying P  Certifying P	hysician: To the miner: On the ba end mann	isis of examin	owledge, deel etion end/or in	th occurred nvestigetion,	et the tin	ne, dete en pinion, dee	d plece, o	end due to the ed et the time,	ceuse(s) e date end p	nd man	ner as ste	eted. the caus	se(s)
	Fo th Fo th	Me	29b. Signature and title of certifier	0			290	Licens	e number			29d. Date	signed	(Month, C	ay, Yea	r)
			) July	the	Ren			2	509	63		7	119	199		
			30. Neme and address of person who	completed cause	e of death (Ita	m 23e) (Tvna	Print\		/	-		/	-//	//		
			Dr. Fulton Luk		. D .			ede	rick	, мг	206	78				
4	Sta	te	31. Dete filed (Month, Day, Yeer)	32. Re	egistrer's Sign	eture	/		,							
	Registr	ar	JUL 2	1 1999	Bene	ww	Ø.	100	acts							



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Date of Death **Physician** JULY Dey 1999 ELEANOR HILLENBRAND 14, 11:00 am /Medical 4a Facility Nema (If not institution, give street and number) Calvert Memorial Hospital 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Prince Frederick Calvert 7. Aga (In yrs. last birthday) If Under 1 Year If Undar 24 Hrs. 5. Social Sacurity Number 8. Date of Birth (Month, Day, NOV 27 9. Birthplece (Stata or Foreign **Funeral** 1912 Pennsylvania Days Hours 1□M 2₩F 86 Yrs. 090 10 5211 Director Usual Rasidance of Decedant with the Meryland 10a State 10c. City, Town or Location 10d. inside City Limits 28a-f show the Medical Examiner must be notified at Maryland Calvert Solomons 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? ò 11450 Asbury Circle # 308 20688 United States items 23a Funeral deeth 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Giva Was Decedant of Hispanic Origin? (Spacify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) Raca - Amarican Indien, Bleck, White, atc. Peges 1 and 2 should be filed within 72 hours effer or not of Heelth end Mental Hygiene. not: if Item 27 is marked other than "naturel", or item 1 □ Navar Marriad 2 □ Married Specwhite Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: þ 3 Widowed 4 □ Divorcad Completed 15. Dacedant's Education 16a. Dacedant's Usual Occupation 16b. Kind of Business/Industry (Giva kind of work dona during most of working life. DO NOT use ratired) (Specify only highast grade completed) Elamentary/Secondary (0-12) Collega (1-4or 5+) homemaker own home 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Sumama) Arthur E. Wilshaw Ella M. Metzgar 19e. Informant's Name/Ralationship (Typa, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) permit. Peges 1 and 2 s Department of Heelth er Important: if Item 27 is any Injury or other treu Joan Hogenson-daughter P.O. Box 504 Solomons Maryland 20688 20a. Method of Disposition 20b. Place of Disposition (Nama of camatary, cremetory or other place) Data 20c. Location - City or Town, Stata Cedar Hill Cemetery 20 1999 Philadelphia Pennsylvania 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nema and Addrass of Facility 21. Signature of Funeral Sarvice Licensae Rausch Funeral Home PA 4405 Broomes Is. Rd. Port Republic Maryland 20676 23a. Part1. Enter the disaasa, or complications that causad tha daath. Do not enter the moda of dying, such as cardiac or raspiratory arrast, shock, or haar failura. List only one ceuse on aach lina. Onsat and Death **Physician** /Medicai Immediata Causa (Final onlymon of disaase or condition resulting in daath) **Examiner** Dua to (or as e consequenca of): Examiner The law requires that the death certificate be executed ettending physician and for use es the buriel-transit Sequentially list conditions, if any, leeding to immadiata causa. Entar Undarfying Cousa (Disaasa or Injury that initioted avants rasulting in daath) Last Due to (or es a consaguança of) P.O. Box 68760, Physician/Medical the Dua to (or as a consaquanca of): Part II. Other significant conditions contributing to death but not rasulting in the underlying cause givan in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed by Records, Completed by 8 24b. Were eutopsy findings evallable prior to 24e. Wes en eutopsy performed? peen completion of causa of daeth? this certificate hes 2 No 1 Yas 1 Tyes 2 No Division of Vital Hospital or Attending Physician: 24 hours efter death. Be 25. Was casa rafarrad to medical axaminar? 26. Placa of Daath (Check only ona) Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 10 2 DW 1 ☐ Yas 1 Dhpatiant 2 ER/Outpatient 3 DOA 27. Manner of Daath 28a. Data of Injury (Month, Day Year) Medical Certification: 28b. Tima of 28d. Describe how Injury occurred 28c. Injury at Work? After 5 Panding investigation 1 Natural 1 TYas 2 No 2 Accidant Director: / 3 Suicida 6 Could not be 28f. Location (Straat and Number or Rural Routa Number, City or Town, Steta) 28a. Placa of Injury - At home, farm, straat, factory, offica building, atc. (Specify) 4 ☐ Homicida within 24 hours eff
To the Funeral Di
completely filled in 29a. Cartifiar 1 Cartifying Physician: To the best of my knowledge, death occurred et the time, deta and place, and due to the cause(s) and manner es stated.

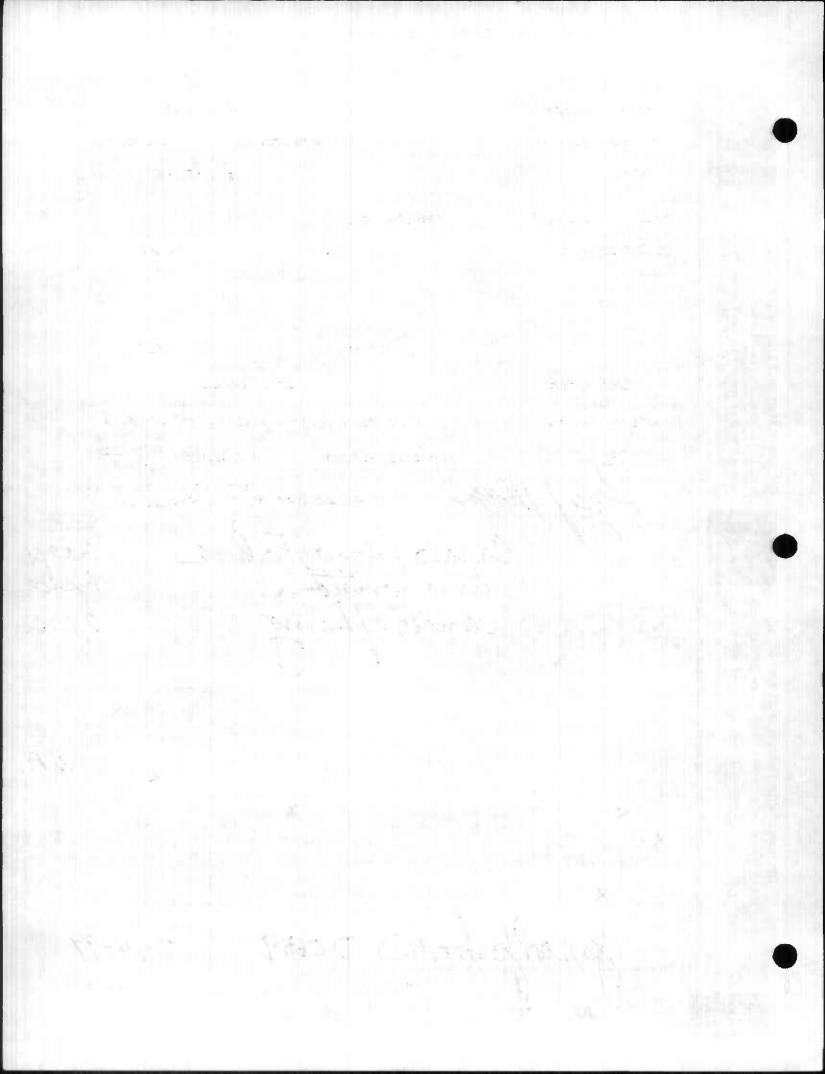
2 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, death occurred et the time, data and place, and due to the cause(s) and manner stated. (Check only one) 8 29c. Licansa number 29b. Signature and title of cartifier 29d. Dete signed (Month, Day, Year) NI 041314 30. Name end eddress of parson who completed causa of daath (Itam 23a) (Type, Print) Dr. Paul Pomilla, M.D., Prince Frederick, Maryland 20678 31. Dete filed (Month, Day, Year) 1 6 32. Registrar's Signature State 1999 Registrar



#### Please Type or Print In Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24064

					Cen	tificate of i	Death		Re	J. No.		
	1. Decedent's Name (Firs	st, Middle, La	est)						Date of Death Month	Day	Year	3. Tima of Death
Physician /Marking	Nancy	Hillod	k						uly 13.	1999	1 481	1:10PM
/Medical Examiner	4a Facility Name (If not in			ber)	-	- 4	b. City, Town			4c. County	of Death	
Examine	Bayside C						Lexingto	on Dari	l-	Ct I	Mary's	
	5. Sociel Security Number			. Age (In yrs. last b	irthday)	If Under 1 Year	If Under 24				-	
Funeral			1 □ M <b>3/</b> □ F	76	Yrs.	Months Days		Min.	Date of Birth (Month, Day,		Cour	lace (State or Foreig
Director	577-24-0877				.,			Dec	cember 7	, 1922	Barto	rsville, VA
	Usuel Residence of Dece	County		10c. City, Toy	um or Loc	ation		-			1	0d. inside City Limits
of H												1 ☐ Yes 2 € No
1 9 0	Maryland	St. Ma	ry's	Lexa	ngtan	Park						10 100 2011
or 28a-1 e	10e. Street and Number					10f. Zip Code			10	g. Citizen of \	What Cour	itry?
8 d =		na Lame				20653				U.S.A.		
et, or items 23a or 28a-f ebow Examiner must be notified at by Funeral Director	11. Marital Status		12. Was Deced	lent Ever in U,S.	13. W	as Decedent of H	ispanic Origin	n? (Specify	Yes or No-		e - Americ	
5 N P	1 ☐ Never Married 2	Married	Armed Ford	es?	if	Yes, specify Cuba	in, Mexican, F	Puerto Rica	an, etc.)	Ble	ck, White,	etc.
by B			If Yes, Give		1	☐Yes 21 No	Specify:			Specify	White	9
d by					01		- 41		1.4	or Mind 48		4
ygiene. Ner than "nature It, tre Medical Completed	15. D (Specify on	ecedent's E ly highest gri	ducation ade completed)	168	(Give k	ent's Usuai Occup	ation during most o	f working		6b. Kind of B	usiness/in	dustry
then then omo	Elementary/Secondary	(0-12)	Coilege (1~	4or 5+)		O NOT use retired				Donald ad		
Hygier drengt dr	12				Jella	l Assistan	L			Dentist	TÀ	
1 2 5 0	17. Father's Name (First,								irst, Middla, M	aiden Suman	ne)	
20 0	E. Clark	Shenk					Loi	is Ho	ttel			
• mar	19a. informant's Name/R	eiationship (	(Type, Print)	19	b. Maiiing	Address (Street	and Number	or Rural Re	outa Number,	City or Town,	State, Zip	Code)
of 7. ie trait	Jeffrey H					Orogan Way					20653	
m 27	20a. Method of Dispositio				_			-		Oc. Location		own State
1 0 m	1 ☐ Buriai 2 ☑ Cre		Removel from S			ition (Name of atory or other place	ce)			Dol+	sville	
15	4 Donation 5 0	Other (Special	(y)	Chesag	œke	Crematory		July	15,1999	Mary		
troi si	21. Signature of Funeur	Service Lice	npoo /		22.	Name end Addre	ss of Facility		7.	_		
ESS	1/10	in 1	1111	1/2	10	01 1/2001 1-0		Ste	rling	runera	1 Ser	vice
-	The State Francisco A	Mg	11ou	was distant. Da	10	01 Kenilwo	EUI AVE	TILE, W	asшyu	D.C.	20019-	Approximate
	23a. Part1 Enter the shook, or heart airu	re. Let only	one causa on aa	ch lina.	HOL GIRG	the mode of dyli	ig, such as co	ardiac or re	Spiratory arro			interval Between Onset and Death
ysician	/	/	1	1.		1	T	- 1	7		- 1	Oriset and Death
fledical	immediata Causa (Final disease or condition		. (4	31011	De	elmond	myto	relle	20	3	1	3 days
aminer	resulting in death)		a	Due to (or as a	- Hasequ	sence of	10					, /
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in end iel-transit Examiner	Conventing the list constitues		b	Due to (or as a consequence of):								,
el-tr	Sequentially list condition if any, leading to immedia causa. Enter Underlying Cause, Oiseass or Injury	ate	/	10.	n A	11.		~				2.1011
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physician end is the buriel-transit edical Examir	resulting in death) Last	1		Due to (or as a	confisequ	engly of):	1	-				11
ding page as		·	d			/						,
for us												
the a hed f	Part ii. Other significant	conditions	contributing to dea	th but not resulting	in the un	derlying cause giv	en in Part i.		23b. Did tot	acco use co	ntribute t	the cause of deat
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be det by P											1	
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should should									perform	ad?	av	allable prior to
hes t												death? NA
page 2 should									1 ☐ Ye	2000	11	Yas 2□ No
rector, page Co	25. Was casa referred to	medical					26. Place o	of Death (C	heck only ons	)	1	
= 0	exa <i>m</i> iner? 1 ☐ Yes 2√2 No		Hospital:	patient 2 ER/C	Outpatient	3□ DOA Oth			5 🗆 Resider		ar (Snacii	(v)
5 7	A		28a, Date of	injury 28b.	Time of			7	. Describe hor			,,
al Director: After the in by the luneral Certification:	1 Naturai 5 □	Pending investigation	(Month	, Day Year)	injury	28c. Injur Wor	k? Yas 2∐No				M.	
	2 ☐ Accident 3 ☐ Suicide 6 ☐	Could not b	100	d lainer date :	law				Location /Du	not and them	har or Di-	al Pouto Alumbas
in by	4 Homicide	determined	289. Placa (	of Injury - At home, i g, etc. <i>(Specify)</i>	erm, stre	et, factory, office		281.	City or Town,		ver or Mult	al Route Number,
To the Funeral Direct completely filled in by Medical Certifical C												
pletely fill edical	29a. Cartifier			est of my knowledg								
mpletely filled Medical Ce	(Check only one)	educat Exa	miner: On the bas end ntanno	sis of examination a er stated.	navor invi	estigation, in my o	pinion, daath	occurred a	st the time, da	e and placa,	and due to	une cause(s)
To the	29b. Signature and title	f certifier	0/1	//	1	29c. Licens	e number		29	d. Date signe	d (Month,	Day, Year)
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	1	0/10	w Lucc	WIEN	M	100	2011			1-1	4-	1/
	30. Nama and add	person who	completed cause	of death (Item 23a)	(Type, F	Print)		1				
	James / F	. Jar	boe M.D	2503	35 ጥh	ree Noto	h Road	HO.	11,000	Mary	hand	20636
State		y, Yaar)		gistrar's Signature	-44	La INOUL	/ IVal	Ay 110.	TTYWU	' LEIT	Tario	20030
Registrar		JUL 1	6 1999	Deneva	1	D. Se	ando	/				
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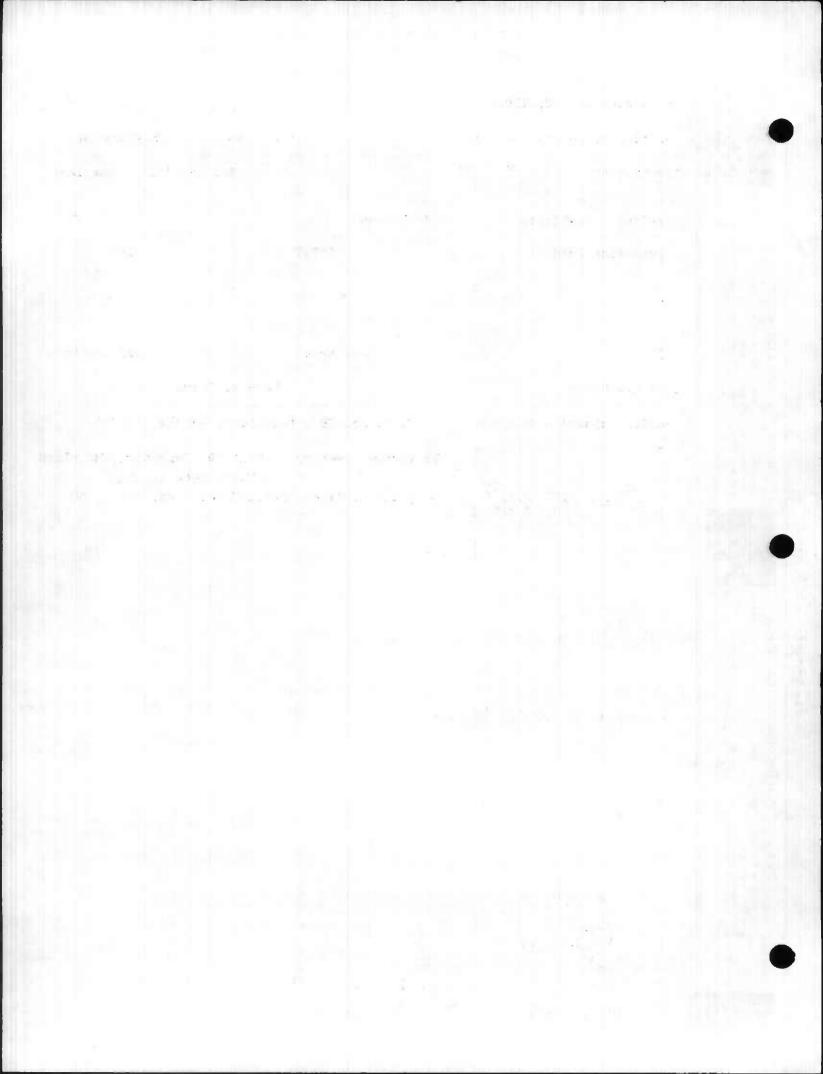
#### Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Deeth 3. Time of Death Day 0925 Month Year **Physician** Katherine Lee ISEMINGER 1999 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, giva street end number) Examiner Washington Washington County Hospital Hagerstown If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Yaar) Birthplace (Stata or Foraign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** Months Days Hours 1 □ M 2 1 F 82 Yrs. 219-52-1458 Dec. 16, 1916 Maryland Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits worle r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 15 Yes 2 No Directo Maryland Washington Funkstown 10e. Street and Number 10f. Zio Coda 10g, Citizen of What Country? 9 Frederick Road 21734 USA death Funeral permit. Pagas 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiena. Important: If frem 27 is marked other them. 14. Race - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Yes 2√ No Spacify: Specify: 2 white 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Dacedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) her own home 12 0 homemaker 18. Mother's Name (First, Middla, Maidan Sumama) 17. Father's Name (First, Middla, Last) Be Carl Lee Moats Lola K. Showe 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) P. O. Box 892, Funkstown, Maryland 21734 Judith Gossard - daughter 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 7-14-99 Funkstown Cemetery Funkstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22, Name and Address of Facility MINNICH FUNERAL HOME 21. Signatura of Funaral Sarvica Licensea Menne 15 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** Avedical Carcinoma Immediate Cause (Final Metastatic disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner requires that the death certificate be executed ed by the attending physician and datached for use as the burial-tran Sequantially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury Dua to (or as a consequenca of): Physician/Medical that initiated avents resulting in death) Lest Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 | Yas 2 | No 3 | Probably 4 | Unknown þ 24a. Was an autopsy performed? 24b. Were autopsy findings evellable prior to completion of cause of daath? Completed page 2 cartificata has 1 Yas 2 DONO 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was case referred to medical 28. Place of Deeth (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 10 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this the funaral 27. Manner of Death Data of Injury (Month, Day Year) 28b. Tima of Injury 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 DNatural 5 Panding Investigation daath. 1 ☐ Yas 2 ☐ No 2 Accident after death 6 Could not be datarmined 3 Suicide 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28e. Placa of fnjury - At home, farm, street, factory, office building, etc. (Spacify) filled in by 4 Homicida To the Hospital o within 24 hours af To the Funerei D edicai 1 [[/ Certifying Phyalofan: To tha best of my knowledga, death occurred at the time, data and placa, and dua to tha causa(s) and mannar as stated. complataly 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and mennar steted. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 29c. License number 15.90 30. Nama and addressed person who completed cause of death (Item 23a) (Type, Print) Waheed 2821 Oak 32. Registrar's Signature 31. Data filed (Month, Day, Year) State JUL 1 6 1999 Registrar

DHMH 16 Rev 6/95

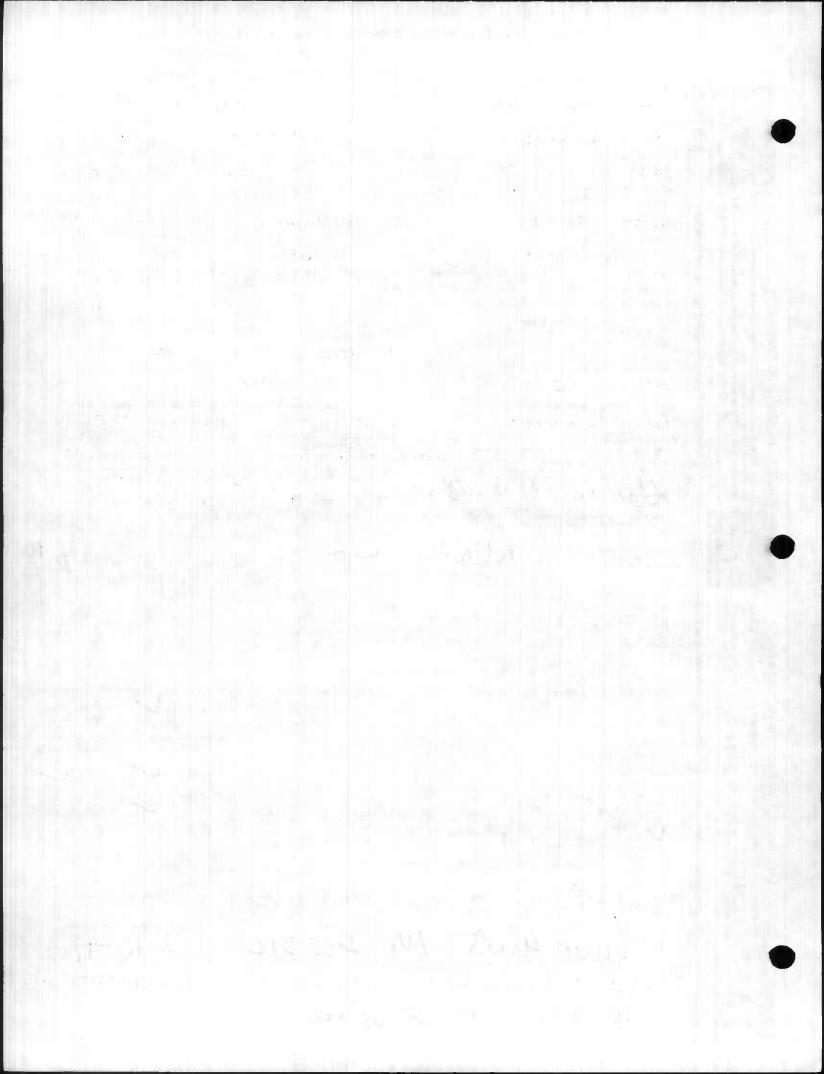
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State of Maryland / Department of Health and Mental Hygiene 9 9 21,056

				Cel	rtificate of	Death		Reg. No.		
Physician /Medical	1. Decedent's Nama (First, Middle Emma Louise	Johnsto	on				2. Data of De Month July	Pay 16	<b>19</b> 99	3. Time of Death 1:35AM
Examiner	4a Facility Nama (If not institution 1107 Washingto		rum <i>ber)</i>				or Location of Deat		of Deeth	
uneral rector	5. Social Security Number 219–12–1822	6. Sax 1 ☐ M 2 🛣 F	7. Aga (In yrs. k	ast birthday) Yrs.	If Undar 1 Yaar Months Days		Hrs. 8. Data of Bin (Month, Did Nov. 5	th ay, Year) 1917	9. Birthp Coun Ma:	laca (Stata or Foraig try) ryland
	Usual Rasidanca of Dacedant  10a. Stata  10b. County		100 Ciby	, Town or Lo	postion				14	Od. Insida City Limits
al', or items 23a or 28e-f show Exempler mass be notified at by Funeral Director		roll	Too. Ony	, rown or Ec		inster				1 ⊠ Yas 2 □ N
ole ello	10e. Street and Number				10f. Zip Coda			10g. Citizen of \	What Coun	try?
la	542 01d West	minster 1	Pike			21157		U.S.A		
by Funeral	11. Maritai Status  1 Nevar Married 2 Marr 3 Widowed 4 Divorced	ied 1 Yas	2 No Giva		Was Decedant of H If Yas, specify Cub 1 ☐ Yas 2 ☑ No		? (Specify Yas or No Puarto Rican, atc.)	Specify	ck, Whita, ov:	etc.
Ped	15. Decedan	t's Education		16a. Daced	dent's Usual Occul	pation		16b. Kind of B		
Completed	(Specify only higha: Elemantary/Secondary (0-12)		(1-4or 5+)	(Giva lifa. i	kind of work dona DO NOT usa ratire	during most of d)	t working			
E	11	Conega	(1-40/54)	S	eamstres	S		sewin	g fac	tory
To Be C	17. Fathar's Nema (First, Middla, William G. Ru.						Nama (First, Middle uise Ermer		na)	
	19a. Informant's Name/Ralations	hip (Type, Pnint)					or Rural Route Numb	per, City or Town,	Stata, Zip	Code)
	Jeanne Bass/ da	aughter		1107	Washing	ton Rd.	Westm	inster,	MD 2	1157
	20a. Mathod of Disposition  1  Burlal 2 Cramation  4 Donetion 5 Other (S		m Stata We	lace of Dispo emafary, crar estmins	osition (Nama of matory or other pla ster Ceme	etery	7/19/99	Westmi		
Physician/Medical Examiner	shock, or haart failura. List Immediata Ceusa (Final disaasa or condition rasulting in daath)  Sequantially list conditions, if any, leading to immediata causa, Entar Undarlying Causa (Disaasa or Injury that inlited avents rasulting in death) Last	a	Due to (or	r es e consec r as a consec as a consec ulting In tha u	quenca of):	van in Part I.	23b. Did	I tobacco use co	ontribute to	Intarval Batween Onsat and Death N
by Phys							1□	Yes 200	3 □ Prol	bebly 4 Unkn
Completed b								s an autopsy ormed?	av:	are autopsy finding aliabla prior to mpletion of causa death?
TO.							1 🗆	Yas 2 No	10	Yas bond
Be (	25. Was case referred to medical axaminar?					26. Place of	Death (Check only	ona)		
10	1 Yas 2 D	Hospital: 1	Inpatient 2	ER/Outpetier	nt 3 DOA Ot	har: 4 🗆 Nursi	ing Homa 5 ☐ Ras	idanca 6 Oth	nar (Specif	residenc
Certification:	27. Manner of Death  1 D Naturel 5 Pandin 2 Accident invasti	g (Mo gation	a of Injury onth, Day Year)	28b. Tima o Injury	Wo	ryat ork? ]Yes 2 ☐ No		how Injury occur	rred	
ertific	3 Sulcida 6 Could datarm	ined 288. Plac	ca of Injury - At ho ding, atc. (Specify	ma, farm, sti	raat, factory, office			(Street and Numi own, Steta)	ber or Rura	I Routa Number,
edicai (	29a. Cartifier (Check only Medical	Examiner; On that	na best of my know basis of axaminati annar stated.	wledga, daati ion and/or in	h occurred at tha ti vastigation, in my	ima, data and p oplnion, daath	place, and dua to the occurred at the time	causa(s) and m	annar es si and due to	lated. the cause(s)
Me	29b. Signature and tyre of certifie	Ku	ils.	MS	D3	sa number	8	29d. Data signe	6 —	Day, Year)
State istrar	31. Data filed (Month, Day, Year)		usa of daeth (Item D 224 Fristrar's Signat	Was	Print) Ninger	Neigh	pho wee	Stminal	er, m	10 211



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** JULY 13, **JOHNSON** JOHN 1999 18:42 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Memorial Hospital Prince Frederick Calvert 5. Social Security Number If Under 1 Yaar | If Under 24 Hrs. 8. Deta of Birth
J. Month, Day, Year, 1938 7. Age (In yrs. last birthday) 9. Birthplaca (State or Foreign **Funeral** XXM 2□ F Months Days Hours 61 Maryland 214-36-3340 Yrs. Director Usual Rasidance of Decedent permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Maryland Department of Haalth and Mental hygiena. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumetic event, the Medical Examinet must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No Directo Maryland Calvert Port Republic 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3095 Hance Road 20676 USA 12. Was Decadent Evar in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yas, Give Year or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working lifa. DO NOT use retired) Elementary/Secondary (0-12) Collaga (1-4or 5+) Laborer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Sumame) Be John Johnson, Sr. Ernestine 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) St. Leonard, MD 20685 Shelly Gray/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremetion 3 ☐ Removal from State Ernestine Jones Cemetery 7/17/99 Chesapeake Beach, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funaral Service Licensee 22. Name and Address of Facility Sewell Funeral Home sewell 1451 Dares Beach Rd. Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Onset and Death **Physician** /Medical Immadiata Cause (Final ung Carcinomy disease or condition resulting in death) Examiner Examiner signed by the attending physician and id be detached for use as the burial-transit Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Causa (Disease or Injury that initiated avants resulting in death) Last Dua to (or as a consequence of): P.O. Box 68760, Physician/Medical Dua to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Obstructive Pulmonan Yes 2□ No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? Laynged Cance completion of cause of death? certificata has 1 Yas 20 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attanding Physician: within 24 hours aftar death. To the Funeral Director: Aftar this certifics 25. Was casa rafarred to medical examinar? Be 26. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidenca 6 Other (Specify) 10 1 Yas 25 No 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA filled in by tha funaral 28a. Date of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be datarmined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spacify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide edical Sertifying Phyaiclen: To the bast of my knowledge, death occurred at the time, data and place, end due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier complataly (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) 30. Nama and addrass of person who complated caute of defith (Itam 23a) (Type, Print) 4 JONATHAN D LOWENTHAL, M.D. Prince Frederick, Maryland 2067.8 31. Data filed (Month, Day, Year) 32. Registray's Signature State

**DHMH 16 Rev 6/95** 

Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

3. Time of Death

ician and bunal-transit that the death certificate be executed physician s the burial 88 esn signed by the a page 2 s certificate or Attending Physician: After this funeral death. 24 hours after deat Funeral Director: filled in by Hospital

Physician/Medical

by

Completed

Be

10

edicai

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth JULY **Physician** JACK VERDEAN LITTLE, SR q 1999 0845 /Medical 4a Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 305 ROCKDALE ST FREDERICK FREDERICK 8. Data of Birth (Month, Dey, Year)
OCT 15, 1930 WAYNESBORO, 5. Sociel Security Number If Under 1 Yeer | If Under 24 Hrs. 7. Age (in yrs. lest birthdey) 9. Birthpiece (State or Foraign **Funeral** 1⊠M 2□F Months Deys Hours Min 177-24-2903 Yrs. 68 **Director** Usuel Residence of Decedent 10d. Inside City Limits ton States 10b. County 10c. City, Town or Location r 28a-f show anotified at PA FRANKLIN WAYNESBORO 1 Yes 2 No Director 94 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23s or the Medical Examiner must be a 11850 ORCHARD LANE 17268 USA Funeral 12. Was Decedant Evar in U.S. Armed Forces? 1 M2 Yes 2 No If Yes, Give 1953570 Yaar or Detas: Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. 11. Marital Status Bieck, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural, or ite ary or other traumatic event, the Medical Extantion 1 Never Merried 2 Married 1 ☐ Yes 2 ▼ No Specify: Specify: WHITE þ 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) DIRECTOR OF SALES MACHINE COMPANY 18. Mother's Neme (First, Middle, Meiden Sumame) 17. Fether's Name (First, Middle, Last) ALSON S. LITTLE GRACE SNYDER 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) LAURIE K. WRIGHT 305 ROCKDALE ST FREDERICK 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Buriei 2 ☐ Cremetion 3 X Removel from Stete Department of Important: If QUINCY CEMETERY 7/12 OUINCY PA 17247 4 Donetlon 5 Other (Specify) 22. Nama and Address of Fecility Grove Funeral Home, Inc. 21. Spring of Funeral Service Licenses 50 S Broad ST Waynesboro PA 17268 ames do Develso ter the disease, or complications that caused the dark. Do not enter the mode of dylng, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Immediete Cause (Finel disaesa or condition rasulting in death) /Medical a Prostate Cancer 1 yr Examiner Due to (or as e consequence of): Examiner Due to (or as a consequence of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that Initiated events resulting in daeth) Last

Due to (or as a consequence of):

Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 No 3 ☐ Probably 4 ☐ Unknown

24e. Wes en eutopsy performed?

24b. Were eutopsy findings aveileble prior to completion of cause of deeth?

1 Yas 2 No

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

daughter's

25. Was case referred to medical examiner? 1 Yes 2 XNo 27. Manner of Deeth

5 Pending

28a. Date of Injury (Month, Dey Year) investigetion 6 Could not be determined 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

1 Inpatient 2 ER/Outpetient 3 DOA 28b. Time of

Other: 4 Nursing Homa 5 Residence 6 NOther (Specific Office) 28c. Injury at Work?

1 ☐ Yes 2 ☐ No

26. Plece of Death (Check only one)

Location (Street and Number or Rural Route Number, City or Town, State)

21701

29a. Certifier (Check only one)

1 Netural

2 Accident

3 Suicide

4 | Homicide

To certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier

29c. License number D 41866

29d. Date signed (Month, Day, Year) July 9, 1999

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

801 Tollhouse Avenue. Kanan Hudhud, MD

Frederick, MD

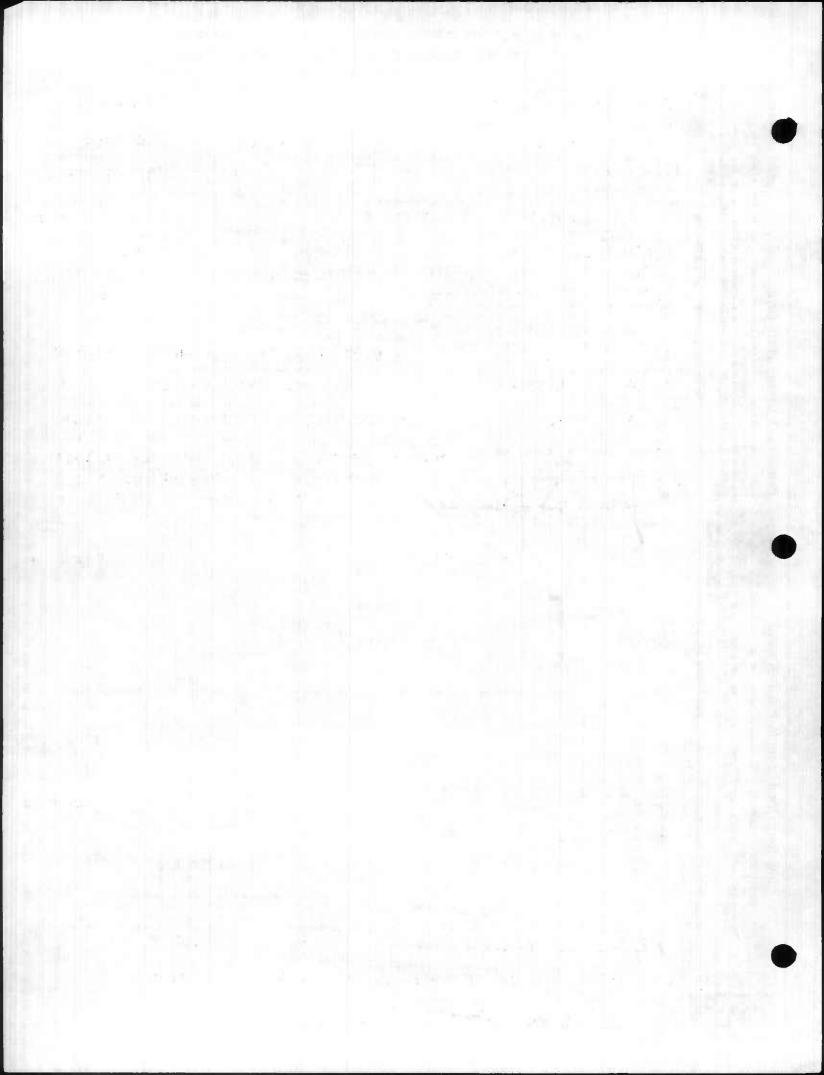
State Registrar 31. Data filed (Month, Dey, Yeer)

32. Registrer's Signature

Spark

D3

To the Hosp within 24 hor To the Fune completely fi



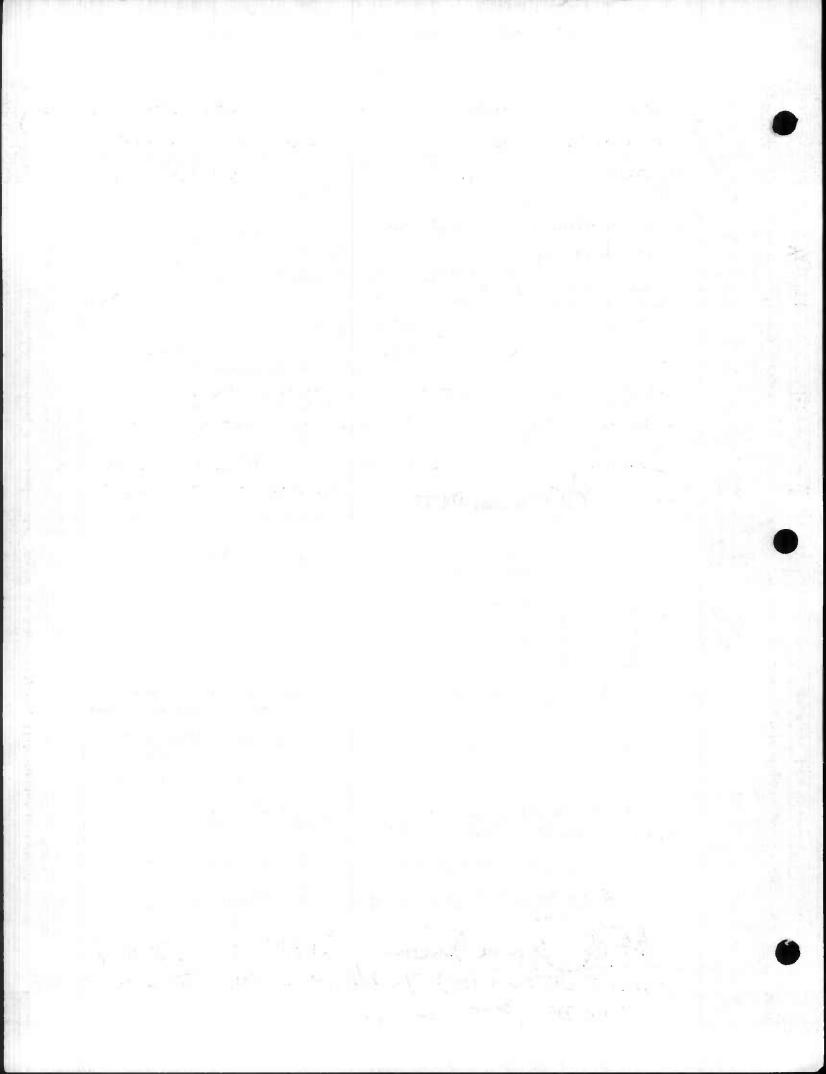
# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		State of Mary		Certificate of			gierie 🔵 🛚 Reg. No.	5	. HODY					
		Decedant's Nama (First, Middle, Last)				2. Data of Dea	ath		3. Tima of Death					
Physicia		James William		League		Month July	7,1999	Year	1210 A.M.					
/Medic Examin		4e. Facility Nama (If not institution, giva streat and number)			4b. City, Town, or Lo		-	of Death						
		Homewood Nursing Home			Williamsp	ort	Washi	ngto	n					
Funeral		MA SUE	yrs. last birth	nday) If Under 1 Year Months Dey	s Hours Min.	8. Data of Birt (Month, Da	h y, Year)		placa (Stata or Foreign intry)					
Director		220-03-3036 X 83		10.		May 9,1	916	_WVa.	•					
anyano ahow ad at	1,21	10a. Stata 10b. County 10	c. City, Town	or Location					10d. Inside City Limits					
th the Maryla or 28s-f shore or 2016sd at	Director		lliams			I			1 ☐ Yas 2 ဩ No X					
長る鬼	Dir	10e. Street and Number		10f. Zip Coda			10g. Citizan of	What Cou	intry?					
inath w	Funeral	16505 Virginia Ave.  11. Marital Status 12. Was Decedant Evar	inUS	2179		acify Yas or No	USA 14 Bac	ce - Ameri	ican Indian,					
or Nerre prices my	Fun	Armed Forcas?  1 Never Married 2 Merried  Armed Forcas?  1 Yas 2 No If Yas, Giva			Hispanic Origin? (Sp ban, Maxican, Puerto	Rican, atc.)	Bie	ck, White,						
- 頻	by	3.☐Widowed 4 ☐ Divorced Yaar or Datas: W	JII	1□ Yas 2⊡ N	o Specify:		Specif	Whi	ite					
72 Trailing	eted	15. Decedant's Education (Specify only highast grada completed)	16e. I	Decedant's Usual Occi Giva kind of work don lifa. DO NOT usa ratir	upation a during most of work	ing	16b. Kind of B	usinass/ir	ndustry					
ed within 72 hour gione. er then "neturel" t the Medical Ex	Completed	Elamentary/Secondary (0-12) Collega (1-4or 5+)		lifa. DO NOT usa ratii 1.ager	red)		Retail							
be filed tal Hygis d other event, ti		12 17. Fether's Nama (First, Middle, Last)		0	18. Mothar's Name	a (First, Middle,		na)						
should be ad Mental marked o	To Be	William Henry Le	eague		Cecelia	Cockrel	1 Lead	110						
		19a. Informent's Name/Raiationship (Type, Print)		Meiling Addrass (Stree			0		ip Code)					
and and a n 27 i		John W. League son		33 Hershey		amsport	,Md.217	95						
Pages 1 hant of H nt: If ther iny or off		20a. Mathod of Disposition 1 ⊠Burlal 2 □ Cramation 3 □ Ramovai from Stata	Ob. Placa of l cematary	Disposition (Nama of , cramatory or other p	lace)	Date	20c. Location	· City or T	own, State					
permit. Pages I and 2 i Department of Health as important: If them 27 is any injury or other trai-			dge Hi	11 Cemetei	y 7	/9/1999	Charle	s To	wn,WVa					
Depart Impo any t		21 Signature of Funaral Sarvice Licensee		22. Nama end Add Burner Tra	de Servici	es	1037 Du	al Pi	1.					
		23a. Part1. Entar the diseasa, or complications that caused tha shock, or heart feitura. List only ona ceuse on each line.	death Done	Hagerstown	Md. 21740	or respiratory as	rrest		Approximata					
Physician		shock, or heart feitura. List only ona ceuse on each line.	Δ		(	or raspiratory at		1	Interval Between Onset and Death					
/Medical		Immediata Ceuse (Finel diseese or condition	My	OCATOGA	· luter	177 En	1	ŀ	Were To					
Examiner		Immediata Ceuse (Finel disease or condition rasulting in death)  a. Hour Mocanica wtarcow Winner  Dua to (or as a consequence of):  Throusconorth												
ed sit	line.	A ATHE	rosco	shofly				i	VIADER					
cate be executed physician and s the burial-transit	Examiner	Sequentially list conditions, if any, laading to immediata	to (or as e co	onsequance of):										
siciar buri	edical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated evants	10/01/00 0											
E 00 00	-	rasulting in death) Last	to (or as a co	onsequence of):				i †						
attending for use as	Physician/N	d						<u>i</u>						
he att	sici	Part II. Other aignificant conditions contributing to death but no	ot rasuiting in	tha undarlying cause of	given In Part I.	23b. Dld 1	tobacco use co	intributs 1	to the cause of death?					
The law requires that the deeth cert ate has been signed by the attending page 2 should be detached for use		Ama Figura	Zy			10	Yss 2 No	3 Pro	bably 10nknown					
uires t	d by	14-2-14				24a. Wes	an autopsy	24b. W	Vara sutopsy findings					
w require been si should	Completed	MAROTHANOIDIA					rmed?	an Co	veilable prior to ompletion of cause I death?					
The lew ate hes page 2	E O					101	es 2 No		□Yas 2□No					
certificate rector, pag	Bec	25. Was casa rafarred to medical			26. Placa of Deat		~							
Physician: this certific el director,	To	axaminar? 1 ☐ Yas 2 No Hospitel: 1 ☐ Inpatient	2 ER/Out	patient 3 DOA	thar: 4 Nursing Ho	me 5 Resid	dence 6 Ott	nar (Speci	ify)					
Ing PI	ü.	27. Menner of Death 1 Selection   28a. Date of Injury (Month, Day Ye	ar) 28b. Ti	ury W	ork?	28d. Describe t	now injury occur	red						
deeth deeth tor: / the f	Icat	2 Accident investigation 3 Suicide 6 Could not be	At home for		] Yas 2 □ No	29f Location /	Street and Num	her or Pu	ral Routa Number,					
or A after Dirac	Certification:	4 Homicide datarmined building, atc. (S		n, straat, factory, office	8	City or Tou	vn, Stata)	rer or mur	ar Houla Number,					
		29e. Certifier (Check only 2) Madical Examiner: On the best of my	knowledge,	daeth occurred et the	tima, data and placa,	and dua to tha	causa(s) and m	anner as	stated.					
the Hin 24 the Figure 1	fedical	one) and mannar stated.	mination and					-						
100 N	×	29b. Signature and the bycertiliar		29c. Lica	pse number		29d. Data signe	d (Month,	, Day, Year)					
		me un percaci	Inter	~ !	11/06	,)	1/11	1/2	7					
		30. Nanya find eddrass of person with completed causa of daath	(item 23a) (T	ype, Print)	Aten/ 4	ful . T	TARLE	(41)	www. look					
Stat	le	31. Date filed (Month, Day, Year) 32/ Registrar's:	Signatura	11-010	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1	11100	4000	10000					
Registra		JUL 0.8 1999	B.	Spark	/									

DHMH 16 Ray 6/95

Baltimore, Maryland 21215-0020

James League Division of Vital Records, P.D. Box 68760,



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death **Physician** 20, 1999 JULY 11:10 P.M. BELVA MAE LITTLETON /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Worcester Berlin Berlin Nursing and Rehabilitation Center If Under 24 Hrs. If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (Stata or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 20 F Hours 218-80-3927 84 Director MD 8/23/14 Usual Residence of Decedent death with the Maryland 10a Stata 10b County 10c. City, Town or Location 10d. Inside City Limits show Worcester Berlin 1 ☐ Yas 2 No Director MD 28a-f 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ò USA 21811 8257 Bethards RD therrie 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11 Marital Status 72 hours after 1 Never Married 2 Married 8 white 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 H VAS GIVE Specify: þ 3℃Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Home 6 17 Father's Nama (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental H ant: If hem 27 is marked oth lary or other traumatic even Be Chloe Timmons James D. Bethards 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Katherine M. Littleton/ Cousin 8206 Bethards RD Berlin, MD 20b. Place of Disposition (Name of cematery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from Stata 7/23/99 Libertytown, MD Riverside Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fanera Service License 22. Nama and Addrass of Facility Burbage Funeral Home 108 William St. Berlin, MD Enter the diseasa, or complications that can sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart allure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disaase or condition resulting In death) metastatic colon concer /Medical Examiner ARDIOVASOUAL DISERS THEROSLIERONC The law requires that the death certificate be executed burial-transit Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last pue Due to (or as a consequence of) physician s the burial Box 68760. Physician/Medical Dua to (or as a consequence of) 82 080 signed by the a P.O. Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yaa 2 | No 3 | Probably 4 | Unknown Division of Vital Records. by 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? certificate has 1 Yes 2 No 1 Yes 2 No or Attanding Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4X Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 24 hours after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, atreet, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and manner as stated. 29a. Certifier Medical letical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 one) o the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifian 29c. License number 30. Name and address of person who completed cause of death (Item-23a) (Type, Print)

9714 Healthway Drive Berlin Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 2 2 1999 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

DHMH 16 Rev 6/95

BELVA

LITTLETON.

White and a

# Sary 21215-0020 Maring

1. Decedent's Name (First, Middle, Last)

5. Social Security Number

Maryland

10e. Street and Number

11 Marital Status

282-24-0461

Usual Residence of Decedent

Gary Albert Moning

4e Facility Name (If not institution, give street and number)

10b. County

1060 Fairview Road

1 Never Married 2 ☐ Married

3 ☐ Widowed 4 ☐ Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

12

Washington County Hospital

15. Decedent's Education (Specify only highest grade completed)

1 1 M 2 □ F

12. Wes Decedent Ever in U,S. Armed Forces?

College (1-4or 5+)

4

1 XYes 2 No 1952— If Yes, Give Year or Dates: 1954

Washington Co.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

.00

Directo

Funeral

P

Completed

Medical

State

Registrar

**DHMH 16 Rev 6/95** 

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

1 6 1999

30. Name an

the Maryland

death

after

Illed within 7 I Hygiene. permit. Pages 1 and 2 should be filled will Department of Health and Mental Hygiene important: If frem 27 ie marked other that any fujury or other traumatic event, the obids. altimore, Maryland Be Henry Albert Moning Laura Eleanor Carlson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13407 Keener Road, Hagerstown, Maryland 21742 19a. Informant's Neme/Relationship (Type, Print) Henry Clarke Moning/Brother 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removel from State Rest Haven Cemetery Jul. 19 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility
Douglas A. Fiery Funeral Home
1331 Eastern Blvd., N., Hagerstown, Maryland 21742 23a. Part1. Enter the disease, or combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical the Due to (or as a consequence of): P.O. P Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Hyperteusion signed by i 1 Yas 2 100 3 Probably 4 Unknown Records, þ Completed 24a. Was an autoosy page 2 s 1 Yes 2 No Division of Vital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 (E) Impationt Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 DNatural 5 Pending s after death. 1 | Yes 2 | No investigation 2 Accident 6 ☐ Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or within 24 hours after To the Funeral Director of the Funeral Director of the Funeral Director of the Funeral Office of the Funeral Offi 4 | Homicide 29a. Certifier (Check only one) 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

1999

Ohio

14. Rece - American Indian, Black, White, etc.

Crane Manufacturing

White

Washington County

4c. County of Death

10g. Citizen of What Country?

USA

Specify:

16b. Kind of Business/Industry

20c. Location - City or Town, Stete

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Deeth

24b. Were autopsy findings available prior to

of death?

29d. Dete signed (Month, Day, Year)

completion of cause

1 ☐ Yes 2 ☐ No

1⊠ Yes 2□ No

, 45Am

2. Dete of Death

8. Date of Birth (Month, Day, Year) Sept. 27, 1929

Month

16. Mother's Name (First, Middle, Maiden Sumeme)

July

4b. City, Town, or Location of Deeth

Hagerstown

If Under 1 Year | If Under 24 Hrs.

Hours

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Days

21742

1 Yes 2 No Specify:

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Senior Stress Engineer

Months

10f. Zip Code

of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

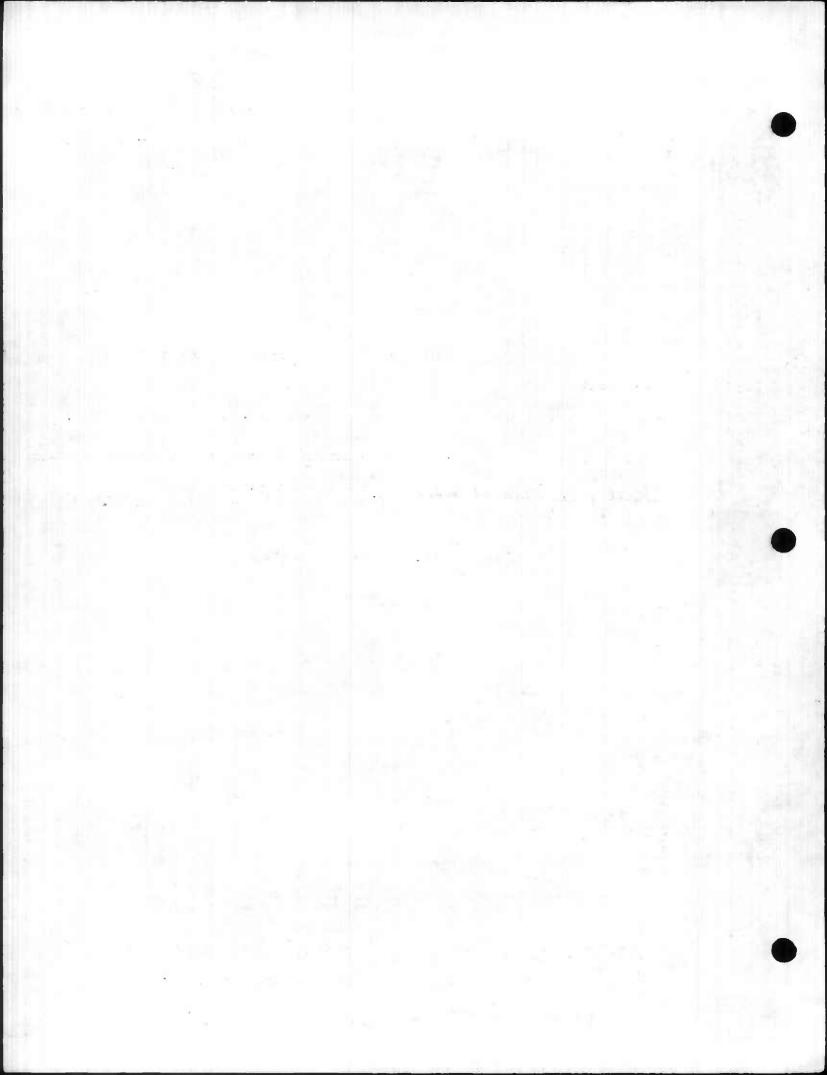
7. Age (In yrs. last birthday)

1954

69 Yrs.

10c. City, Town or Location

Hagerstown



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death SCOTT McCORKLE MITCHELL SR. 4b. City, Town, or Location of Death 4a Facility Nama (If not Institution, give street end number) 4c. County of Death WASHINGTON COUNTY HOSPITAL HAGERSTOWN WASHINGTON If Under 1 Year If Under 24 Hrs. 8. Data of Birth Hours Min. (Month, Day, Year) 7. Age (In yrs. lest birthday) Birthplaca (State or Foreign Country) 5. Social Security Number 1⊠M 2□F Months Days TENNÉSSEE 410-24-1851 79 JAN. 14, 1920 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yas 2 X No ROHRERSVILLE MARYLAND WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 21779 3701 CLEAR RUN PLACE U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerlo Ricen, etc.) 12. Was Decedent Evar In U,S. Armed Forcas? 1 ☑ Yes 2 ☐ No 1941— If Yas, Give 1052 14. Race - American Indian, Bleck, White, etc. 1 Naver Married 2 Married 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 1952 Year or Detes: WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade complated) Elementary/Secondary (0-12) College (1-4or 5+) ENGINEER ELECTRONICS MANUF. 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) WILL POINDEXTER MITCHELL NELL RUTH McCORKLE 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Relationship (Type, Print) ANN S. MITCHELL/SPOUSE 3701 CLEAR RUN PLACE, ROHRERSVILLE, MARYLAND 21779 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 5 Other (Specify) SMITHSBURG CREMATORY 7/15/99 SMITHSBURG, MARYLAND 21. Signature of Funeral Service Lie 22. Name and Address of Facility 7606 Old National Pike BAST FUNERAL HOME 23a. Part I. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Boonsboro, Maryland 21713 Approximate Interval Between Onset and Death Immediete Cause (Final 2 days ineu monia disaasa or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Progressive Supranucleur Polary 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy

**Physician** /Medical **Examiner** 

physician at the burial-t

1080

Examiner

Physician/Medical

þ

Completed

Be

To

Certification:

edicai

**Physician** 

/Medical

**Examiner** 

Directo

Funeral

à

Completed

å

**Funeral** 

Director

mant be r

r than "natural", or lierns the Medical Examiner my

. Pages 1 and 2 should be III ment of Health and Mental H ant; if item 27 is marked oth lury or other traumatic even

Baltimore, Maryland 21215-0020

Sequentially list conditions, if any, leading to immediate causa. Entar Undarlying Cause (Diseasa or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Yas 2 No

28d. Dascribe how injury occurred

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27	Manageral	Dooth	_	
	1 Yes	2 No		
20	examiner?			111001001

1 Natural 5 Pending Investigation 2 Accident

28a. Date of Injury (Month, Dey Year) 6 Could not be determined

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28c. Injury at Work? 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

3 ☐ Suicida

4 Homicide

🗠 Certifying Physictan: To the best of my knowledge, death occurred et the time, dete end place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. Licansa number

29d. Date signed (Month, Day, Year)

My hund MO

7.15.95

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

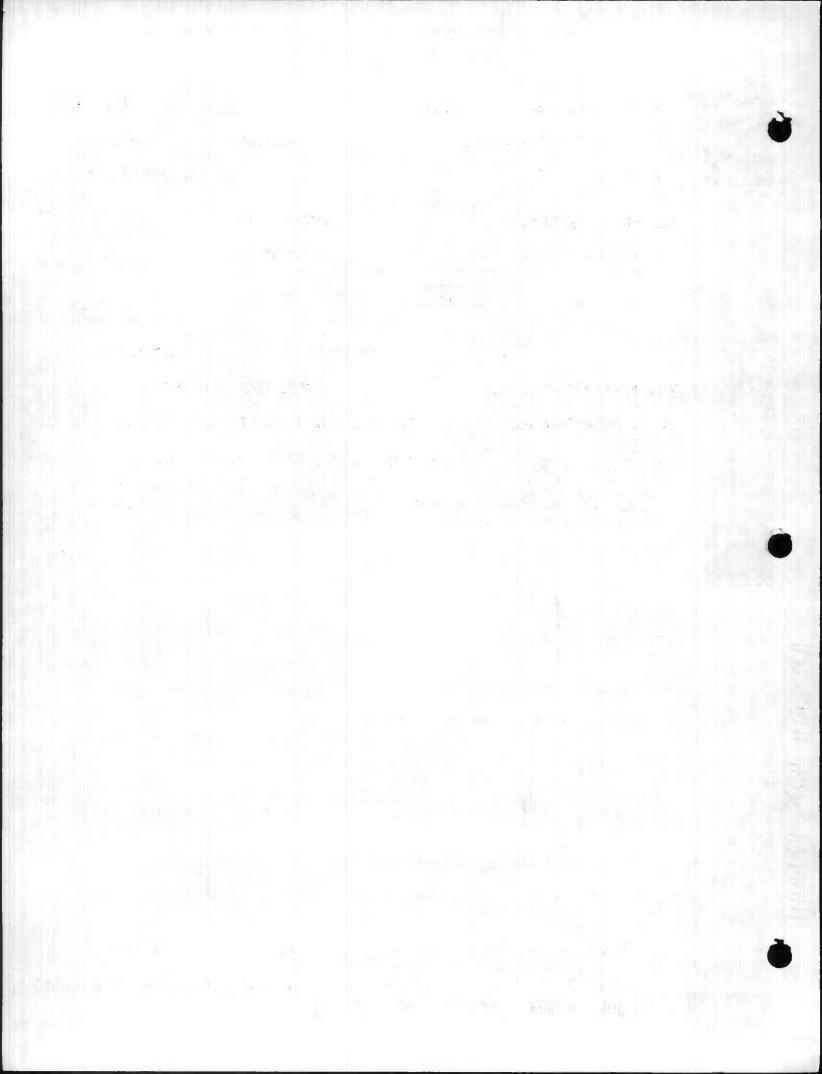
McCornack 11110 1°6'1999

State Registrar

Medical Canyon Ad. Hagerstown MD 21742 32. Pegistrar's Signature

24 hours a Funeral

Within 2 To the F



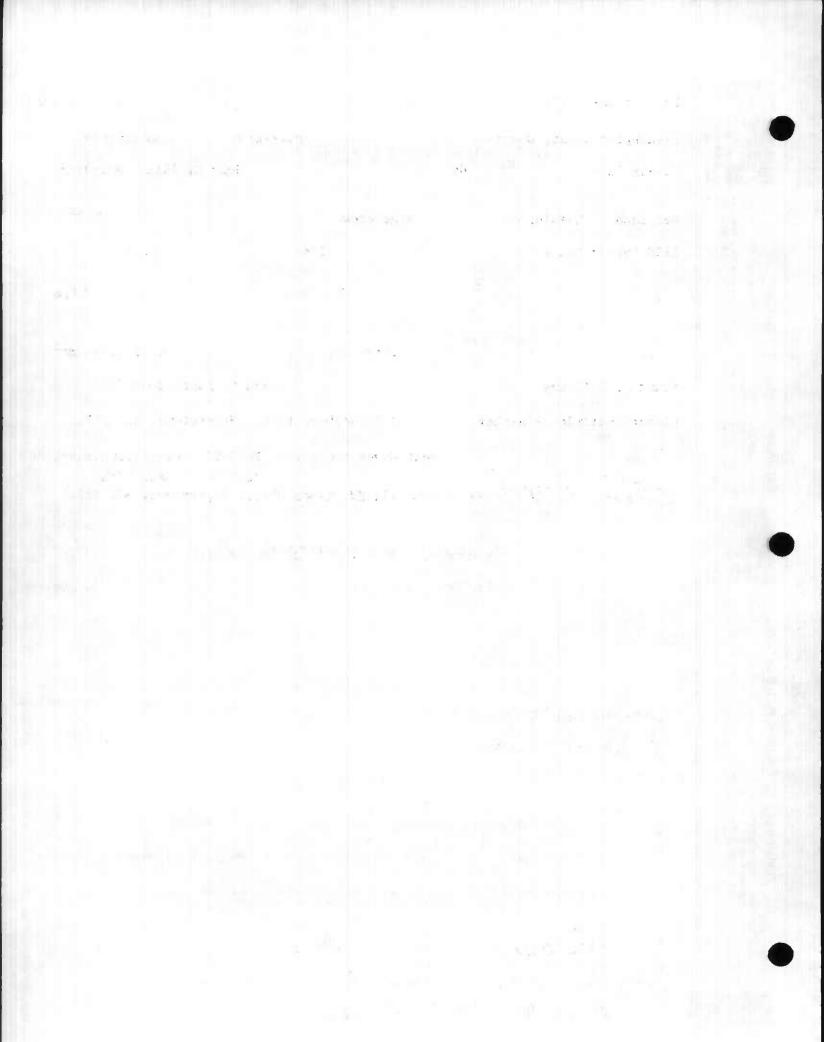
## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

						Certificate of		Ro	eg. No.	lej.	4070
	Physicia	ın	1. Decedent's Neme (First, Middle, Last) Ruth Louise MOSER					2. Dete of Deat Month	Dey	Year	3. Time of Death
	/Medic	al	4a Fecility Neme (If not Institution, give stre	et and number)			4b. City. Town, or Lo	July ocation of Death	4c. County	of Death	0131
A	Examin	er	Washington County H				Hagerst			hingt	on
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M	7. Ag	e (In yrs. last bir	hday) If Under 1 Year Months Days	r If Undar 24 Hrs.	8. Deta of Birth (Month, Day, July 8,	Year)	9. Birthpla Countr	oce (Stete or Foreign y) 1and
	and *	1	Usuel Residence of Decedent  10a. Stete 10b. County		10c. City, Town	n or Location				100	d. Inside City Limits
	Mary	to	Maryland Washing	ton	I	Hagerstown				4/7	MXYas 2 No
	x 28s	i e	10e. Street end Number			10f. Zip Coda		1	0g. Citizen of V	Vhat Countr	y?
	23a d	a	1158 Luther Drive				1740		US	A	
020	d 2 should be filed within 72 hours efter death with the Maryland hand Mental Hygiene. 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified a	by Funeral Director	1 Never Merried 2 Married	Was Decedant I Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Yeer or Detes:		13. Wes Decedent of If Yes, specify Cult		ecify Yas or No- Rican, etc.)		e - America k, White, et	
Maryland 21215-0020	thin 72 hore.	Completed	15. Decedent's Educati (Specify only highest grade co			Decedent's Usuel Occu (Give kind of work done life. DO NOT use retin	a during most of work	ing	16b. Kind of Bu	usiness/Indu	stry
2	filed within Hygiene. other than ent, the Menter th	Con	12 +			secretary	T :2	(F) - A 1 4 ()			rnment
and	ntal H	Be	17. Fether's Neme (First, Middle, Last)				18. Mother's Nam				
2	2 should be and Mental is marked or aumatic eve	10	Frank D. Hollyday  19e. Informent's Neme/Reletionship (Type,	Print)	196	. Meiling Address (Stree		a E. Lea			Code)
	and 2 saalth ar n 27 is		Richard Helfrich -				orn Blvd.				
ore,	- 1 5 5	-	20e. Method of Disposition	i	20b. Plece of	Disposition (Name of y, crematory or other pl			20c. Location -		
altimore,			1 ☐ Burial 2 ☐ Cremetion 3 ☐ Rem 4 ☐ Donetion 5 ☐ Othar (Specify)	ovel from Stata	Rest	Haven Cem	etery 7-	-15-99	Hagers	town,	Maryland
Ball	permit. Pag Department Important: It any Injury o		21. Signeture of Funeral Service Licensee	22	1	22. Nama and Addi	ress of Fecility M	ENNICH F	UNERAL	HOME	
	20599		Day	Kem	well		lson Blvd.				
*	Physician /Medical		23a. Pert1. Enter the diseese, or complication shock, or heert feilure. List only one commendate Ceuse (Final	euse on eech lir	16.			,	ast,	1 1	Approximete interval Between Onset end Deeth
	Examiner		diseese or condition resulting in deeth) e	HCM	Due to (or es e	yocardia	1 Intar	ction		1	7 1000.
	D #	Je		Athe	eroscl					le	nknoun
	ificata be axecuted g physician end as the bural-transit	Examiner	Sequentially list conditions,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		consequence of):					
60,	be ax lician burial	E E	Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events								
68760		edicai	resulting in deeth) Lest		Due to (or as e o	consequence of):				1	
Box	attanding	2	d								
	death	sicia	Pert fl. Other eignificant conditions contrib	uting to death be	ut not resulting Ir	n the underlying cause g	given in Pert I.	23b. Did to	bacco uae co	ntribute to	the ceuse of death?
0.0	res that the daz signed by the at the deteched for	Phy	Caralnina M	L 00 -	. +			1 🗆 Y	ee 2□No	3 Prob	ably 4 Unknow
ds,	The law requires that the death cert its has been signed by the attanding page 2 should be deteched for use	Completed by Physician/M	Pulmonary 7.	proca				24e. Wes e	n outonov	24h Wei	re eutopsy findings
Vital Hecords,	w require been si should	etec	Pulmonary 7.	brose	)			perform		com	ileble prior to apletion of cause eeth?
ě	nysician: The law his cartificate has b I director, page 2 s	ф						1 🗆 Ye	es 200 No		Yes 2□No
<u>ra</u>	In: T tificat tor, pa	Be C	25. Wes case referred to medical				26. Place of Deel				
<u>&gt;</u>	Physicil this car ral direc	10	axeminer? 1 ☐ Yes 2 ☑ No Hosp	oitel:	nt 2 DERVOU	tpatient 3 DOA	ther: 4 Nursing Ho	ome 5 Reside	ence 6 🗆 Oth	er (Specify)	)
	Ing Pt			28e. Dete of Injur (Month, Day	y Year) 28b. 1	rime of 28c. Inj	ury et ork? ☐ Yes 2 ☐ No	28d. Describe he	ow injury occur	red	
DIVISION	at or Attanding Physical States at the death.  I Director: After this of in by the funeral of	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Pleca of Inju-		rm, street, fectory, office		28f. Location (Si City or Town	treet end Numb n, Stata)	per or Rural	Routa Number,
	To the Hospital or Attending Physician: within 24 hours after deeth.  To the Funeral Director: After this cardific completely filled in by the funeral director.	edical	29a. Certifier (Check only one)  12 Certifying Phyelcia 2 Medical Examinar:		examinetion en						
	To the comp	Ž	29b. Signatura and title of certifiar			29c. Licer	nse number	2	9d. Dete signe	d (Month, D	Dey, Year)
			> N Vedu	1/		5	46561		7-14	-99	
			30. Name and address of person who comp		Pairma	. 01	Ramonl	oro mo	1		
	Stat		31. Dete filed (Month, Day, Year)	1	er's Signature	n Ka.	moon	, prid			

State

Registrar

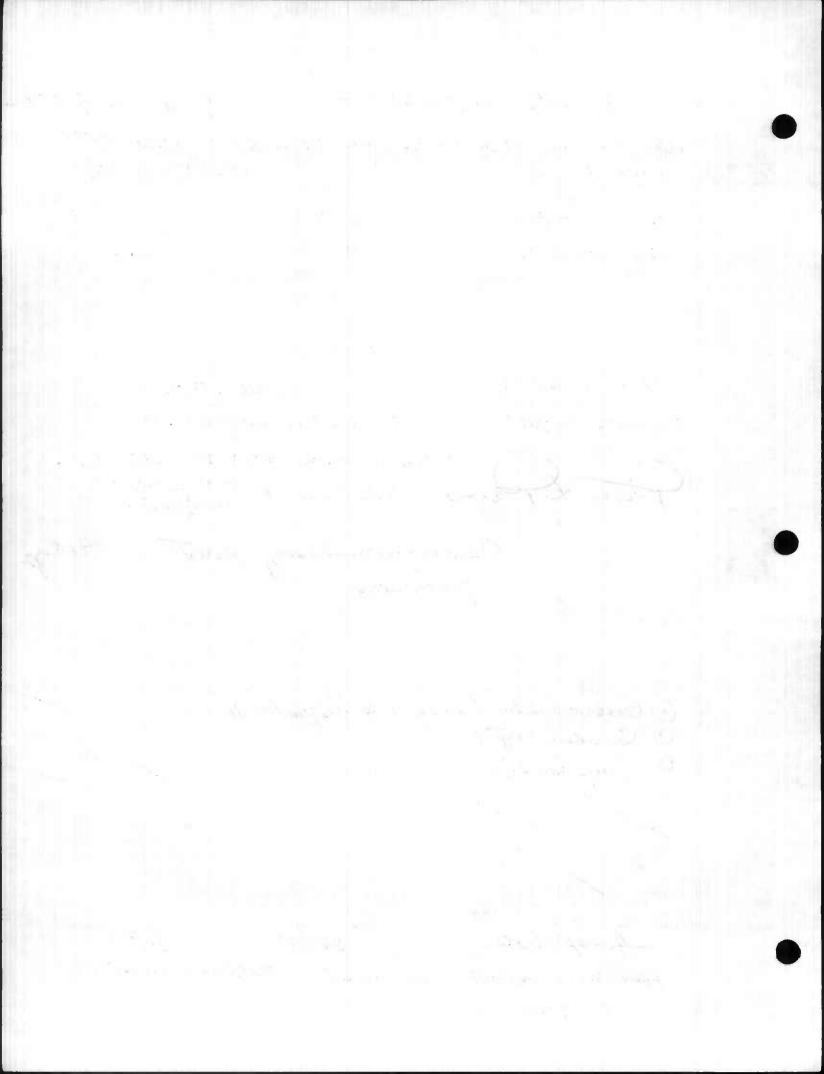
JUL 1 6 1999



State of Maryland / Department of Health and Mental Hygiene

			State of Mary		ificate of	Death		eg. No.	24074
	Physic /Medi		1. Decedent's Neme (First, Middle, Last)  RANK  MA	RMAD	UKE	_	2. Dete of Deet Month	h	Yeer 4,25 pm
	Exami		4e. Fecility Neme (If not institution, give street end number)  ### Application    5. Sociel Security Number    6. Sex    Application    6. Sex	yrs. lest birthday)	tender 1 Year	4b. City, Town, or Local HAGEAST if Under 24 Hrs.	DUN	4c. County o	unston
	Funeral Director		214-34-0494 1 X M 2□ F 62  Usuel Residence of Decedent	y. c. 1001 Dillarday)	Months Deys	Hours Min.	8. Date of Birth Feb. 4,	1937	9. Birthpiece (Stete or Foreign Malyland
	Maryland of show	tor		c. City, Town or Loca	tion Hagerst	town			10d. Inside City Limits 1 XYes 2 No
	th with the 23a or 28a	ai Direc	10e. Street end Number 621 W. Franklin St.		10f. Zip Code 21740		1	Og. Citizen of WI	
020	72 hours effer deeth with the Maryland "natural", or Items 23a or 28a-f show ideal Examiner must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Novorced  12. Was Decedent Ever Armed Forces?  1 Yes 2 No If Yes, Give Yeer or Detes:		as Decedent of H es, specify Cube	lispenic Origin? (Spe en, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)		- American Indien, , White, etc. White
21215-0020	2 2	Completed	15. Decedent's Education (Specify only highest grede completed)  Elementery/Secondary (0-12)  College (1-4or 5+)	(Give kir life. DC	nt's Usuel Occup nd of work done NOT use retired Painter	etion during most of workin d)	ng	16b. Kind of Bus	
	should be filed within end Mental Hygiene. s marked other than aumatic event, the Mental than the Mental transfer event, the Mental transfer event, the Mental transfer event, the Mental transfer event, the Mental transfer event, the Mental transfer event, the Mental transfer event, the Mental transfer event, the Mental transfer event, the Mental transfer event, the Mental transfer event events event events event	Be	17. Fether's Neme (First, Middle, Last) William B. Marmaduke			18. Mother's Name			)
, Maryland	1 end 2 should Health end Mer em 27 is marke ither traumatic	To	19e. Informent's Neme/Relationship (Type, Print)  Tammy Heare (Daughter)			end Number or Aure.  Ave. Hage	Route Number	City or Town, S	
Baltimore,	permit. Peges 1 end Depertment of Health Important: If Item 27 any Injury or other tr once.		20a. Method of Disposition 20 1 Burial 2 Orcemetion 3 Removal from State	Ob. Plece of Disposit cometery, crema Smiths burg		tory July			city or Town, State hsburg, Md.
Bal	permit. Depertra Importa any injt		M. Signature & Funeral Spanion Libertee	Day		eral Home	Smiths	Bradburi burg, Md	
	Physician /Medical		23a. Pert1. Enfer the disease, or complications that caused the shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	Deopul			respiretory erre	est,	Approximete Intervel Between Onset end Deeth
	Examiner	Iner		to (or es a conseque	ence of):	0	pose,	7	P
x 68760,	the death certificete be executed by the ettending physicien end sched for use es the burial-transit	/Medical Examiner	if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that injury c.	to (or es e conseque	ence of):				
O. Box	res that the death cer signed by the ettendir be deteched for use	Physician/	Part II. Other significant conditions contributing to death but not		erlying cause giv	en in Pert I.			tribute to the cause of death?
S, P	ires thet signed to d be deta	by	O Cerebrovosculon ac	whood	4 Sei	Zu Mise	24e. Wes e	n eutopsy	3 Probably 4 Onknown  24b. Were eutopsy findings evailable prior to
Record	hes b	Completed	3 Hyperlan Sim				1 🗆 Ye		completion of cause of deeth?
Vital	iclan: certific rector,	o Be	25. Was case referred to predict examiner?  1 Yes 2 Hospitel: 1 Impatient	2 ☐ ER/Outpefienf	3□ DOA Oth	26. Plece of Deeth er: 4 ☐ Nursing Hom			r (Spacify)
Division of	the fact	cation: T	27. Menne of Deeth  1 Neturel 5 Pending (Month, Dey Yee investigation	28b. Time of	28c. Injur Wor	v et 2		w injury occurre	
Divi	To the Hospital or Attendivithin 24 hours effer death.  To the Funeral Director: A completely filled in by the formal complete of the for	Certification:	3 Suicide 6 Could not be determined 28e. Pleca of Injury building, etc. (Sp	pecify)			City or Towr	n, Stete)	r or Rurel Route Number,
	the Hosp nin 24 ho the Fune npletely f	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my 2 Medical Examiner: On the basis of examend menner steted.	knowledge, deeth on ninetion end/or Inves	stigation, In my o	pinion, deeth occurre	d et the time, de	ete end plece, ar	nd due to the cause(s)
	To To con	~	29b. Signeture and title of certifier  Acust find the control of t			7898		7/11/9	
			30. Name and address of person who completed cause of death FRAN CISCO L, ANDRADE			T. HAGE	RSTOWN	V MO	21740
	Sta Registr		31. Dete filed (Month, Dey, Yeer)  JUL 13 1999  32. Registrer's S	ignature &.	Som	61			

DHMH 16 Rav 6/95

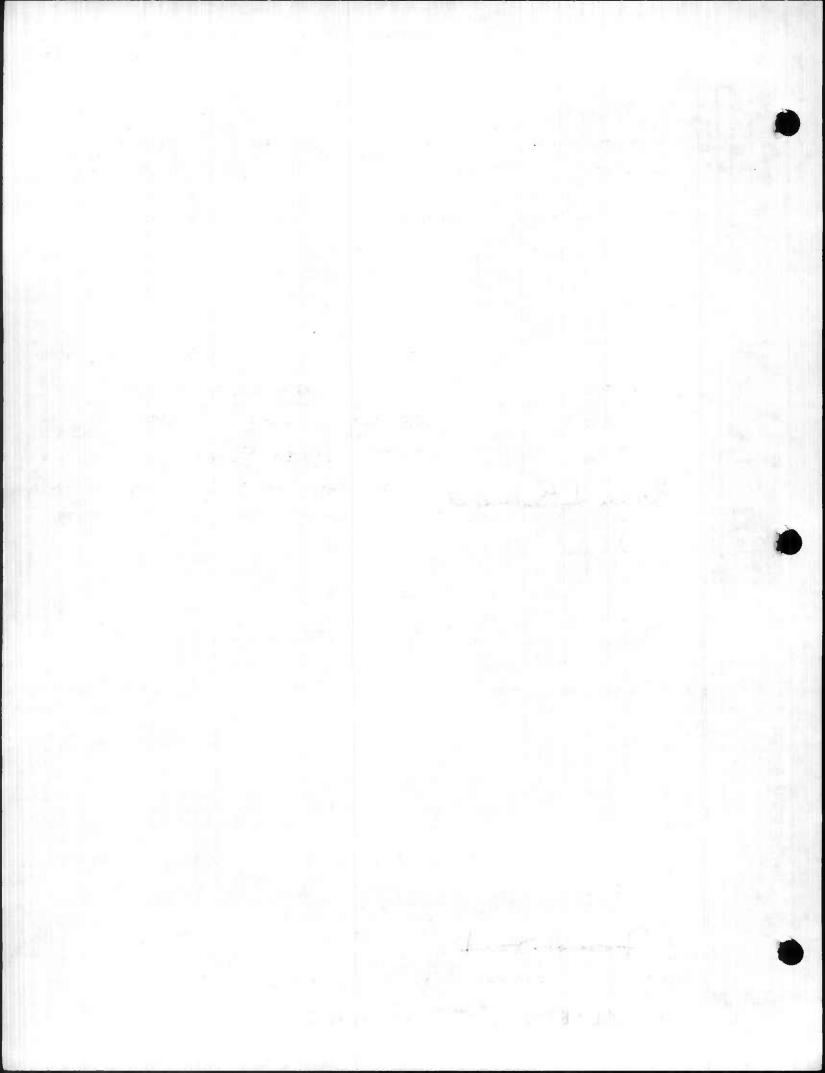


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dev **Physiclan** Month Glenda Kay Mumma July 15 8:35 a.m. 1999 /Medical 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Western Maryland Hospital Center Hagerstown
If Under 24 Hrs. 8.1
Hours Min. 8. Dete of Birth (Month, Dey, Year) Washington If Under 1 Year Sociel Security Number 7. Age (In yrs. lest birthday) Birthpleca (Stata or Foreign Country) **Funeral** 1□ M 2🛛 F Deys Months 198-34-6929 Yrs 1947 Director Waynesboro Usual Residenca of Decedent death with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral', or items 23a or 28a-f show Examiner must be notified at PA Franklin Waynesboro Director 1 Yas 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 345 Antietam Dr. 17268 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Giva Yeer or Detes: Rece - American Indien, Bleck, White, etc. 11. Maritel Status Wes Dacedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Maxican, Puarto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
snt: If Item 27 Is marked other than "natural", or Health or other traumatic event, the Monical Examines. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 white 1 ☐ Yes 2 No Specify. by 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 Shipping/Delivery Company Bookkeeper 17. Fethar's Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be J. Paul Whitlock Alberta J. Bricker 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Eric C. Mumma 14969 Ridge Rd. Waynesboro PA 17268 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Dete 1 ☐ Burial 2X Cremation 3 ☐ Removel from Stata July 16 Department of Important: If any Injury or Omberland Valley Crematorium 4 ☐ Donetion 5 ☐ Other (Specify) 1999 Waynesboro PA ature of Funeral Service Licensal 22. Name and Addrass of Facility 50 S. Broad St. Waynesboro 17268 Grove Funeral Home umes owerso 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Betw Onset end Deeth Physician /Medical Immediete Cause (Finel Electrolyte imbalance disease or condition resulting in deeth) Examiner Due to (or as e consequance of): Examiner End Stage Renal Disease The law requires that the death cartificate be executed the burial-transit Sequentielly list conditions, if eny, leeding to immediate causa. Entar Underlying Ceusa (Disease or Injury that initiated events resulting In deeth) Lest Due to (or es e consequence of): P.O. Box 68760, Diabetes Mellitus Physician/Medical Due to (or es e consequença of): 88 950 is certificate has been signed by the atterdirector, page 2 should be detached for Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 N Unknown of Vital Records, þ 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? 1 Yes 2 No this certificate 1 ☐ Yes 2 ☐ No rapital or Attending Physician: Theoris after death.

Ineral Director: After this certificate y filled in by the funeral director, pa Be 25. Was case referred to medical 28. Plece of Deeth (Check only one) 2 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Nonpatient 2 ER/Outpetient 3 DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) Medical Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Division 1X Naturel 5 Pending 1 Yes 2 No Invastigation 2 Accidant 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, atc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 4 | Homicide To the Hospital ( within 24 hours at To the Funeral D. 29e. Certifier 🎦 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as steted. 2 Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and menner stated. 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) D41112 July 15 1999 30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print) Ian H. Newbold 1500 Pennsylvania Ave. 21740 Hagerstown MD 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Amended line 5. Certificate of Death SC 7-14-99 WCHD 2. Dete of Death 1. Decedent's Neme (First, Middle, Last) **Physician** Edward Joseph MILLER 5:25 July /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death **Examiner** Washington County Hospital Hagerstown Washington 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 9. Birthplece (Ste Country)
Sept. 26,1929 Maryland Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthday) **Funeral** 1⊠M 2□ F Months Deys Hours 69 Yrs. 214-26-<del>1307</del>1304 Director Usuel Residence of Decedent the Maryland 10d. inside City Limits 10b. County 10c. City. Town or Location 10e State show Nem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 17817 Red Oak Drive 21740 U.S.A. Funeral death 14. Race - American Indien, 12. Wes Decedent Ever in U,S.
Armed Forces?

1 🖾 Yes 2 🗆 No 1948 Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Stetus permit. Peges 1 and 2 should be filed within 72 hours after of Department of Health and Mentel Hygiane. Introcrant: if Nem 27 is marked other than "natural, or tien any injury or other traumatic event, the Medical Experimental page. Bleck, White, etc. 1 ☐ Never Married 2 Married Specify: White Maryland 21215-0020 1949 1 Yes 2X No Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) state highway adminis 0 - 12engineer 18. Mother's Neme (First, Middle, Meiden Surneme) 17. Fether's Neme (First, Middle, Last) Be Raymond M. Miller Theresa M. Dettmer 0 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. informant's Name/Relationship (Type, Print) Mrs. Ruth Miller/wife 17817 Red Oak Drive, Hagerstown, Maryland 21740 altimore, 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, State July 12, 1999 1 XBurial 2 Cremation 3 Removal from State Cedar Lawn Memorial Park Hagerstown, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Servica Licansee 22. Name and Address of Fecility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 L Vistel 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Deeth **Physician** /Medical Immediete Cause (Finat disease or condition resulting in deeth) **Examiner** Examiner nake Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest and burial-tran that the death certificate be execu physician s the burial oronary Physician/Medical use as 125 angral signed by the e Pert II. Other significant conditions contributing to death but not resulting in the undertying cause given in Part 8 23b. Did tobacco use contribute to the cause of death? FibrallaTion 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, À 24b. Were autopsy findings available prior to 24e. Wes en eutopsy Completed completion of cause of deeth? has 1 Yes 2 No 1 Yes 2 No certificate I or Attending Physician: after death. Director: After this certific funeral director, 25. Was case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? Certification: 1 Neturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) and menner as ateted. edical 2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) end menner stated. (Check only To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ase of death (Item 23s) (Type, Print) 30. Name Mc

State Registrar 0101 I america granta

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 1999 3:15 AM JULY 8, Helen Irene MYERS /Medical 4a Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner RAVENWOOD LUTHERAN VILLAGE HAGERSTOWN WASHINGTON If Under 1 Year Birthplace (State or Foreign Country) 5. Sociei Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 M 2 XF Director 220-48-3101 94 March 10 1905 West Virginia Usuel Residence of Decedent the Maryland 10e State 10b. County 10c. City. Town or Location 10d Inside City Limits show XTYes 2 No Director 28a-f Maryland Washington Hagerstown 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? b must be 238 448 East First Street 21740 Funeral U.S.A.
14. Race - American Indien, 12. Was Decedent Ever in U,S. Armed Forceş? 1 ☐ Yes 2 ☑No If Yes, Give Yeer or Detes: Berral. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 ☐ Never Merried 2 ☐ Merried Saltimore, Maryland 21215-0020 1 Yes X No Specify: Specify: þ 3 ☐(Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Founder Block Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be in ment of Health and Mental H ant: If them 27 is marked oth lary or other traumatic even Be Josephus Marshall May Baker 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vernon Myers - Son 1155 The Terrace Hagerstown, Md. 21742 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State Date 1 ☑ Buriet 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Rose Hill Cemetery 7/12/99 Hagerstown, Maryland 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 finneel 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tellure. List only one cause on each line. Approximete Intervet Between Onset and Death **Physician** /Medical Immediate Cause (Finet ACUTE PULMONARY EDEMA disease or condition resulting in death) 12 HOURS Examiner Due to (or as a consequence of): Examiner CHRONIC CONGESTIVE HEART FAILURE MANY YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es e consequence of): physician s the buria Box 68760. ISCHEMIC CARDIOMYOPATHY MANY YEARS Physician/Medical Due to (or es a consequence of) P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 1 Yes 2 No 3 Probably 4 Unknown should be det DIABETES MELLITUS, HYPERTENSION Records. P 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy RECENT PNEUMONIA (MARCH 1999) 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No certificate OLD CEREBRAL INFARCTION of Vital Physician: Be 25. Was case reterred to medical 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4D Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28e. Dete of Injury (Month, Day Year) 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After Division 1 DNeturel Attending 5 Pending i or Attendination after death. 1 Yes 2 No investigetion 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, term, street, tectory, office building, etc. (Specify) 4 Homicide filled in Hospital
 24 hours a
 Funeral D edical 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) completely 2 Medical Examinar: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stelled. within 2 To the ş 29d. Date signed (Month, Day, Year) 29b. Signeture end title ot cartifier 29c. License number

Registrar

State

HELEN

1190 MT. AETNA ROAD, HAGERSTOWN,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrer's Signeture

EDSON MOODY M.D.,

JUL 1 4 1999

31. Dete tiled (Month, Day, Year)

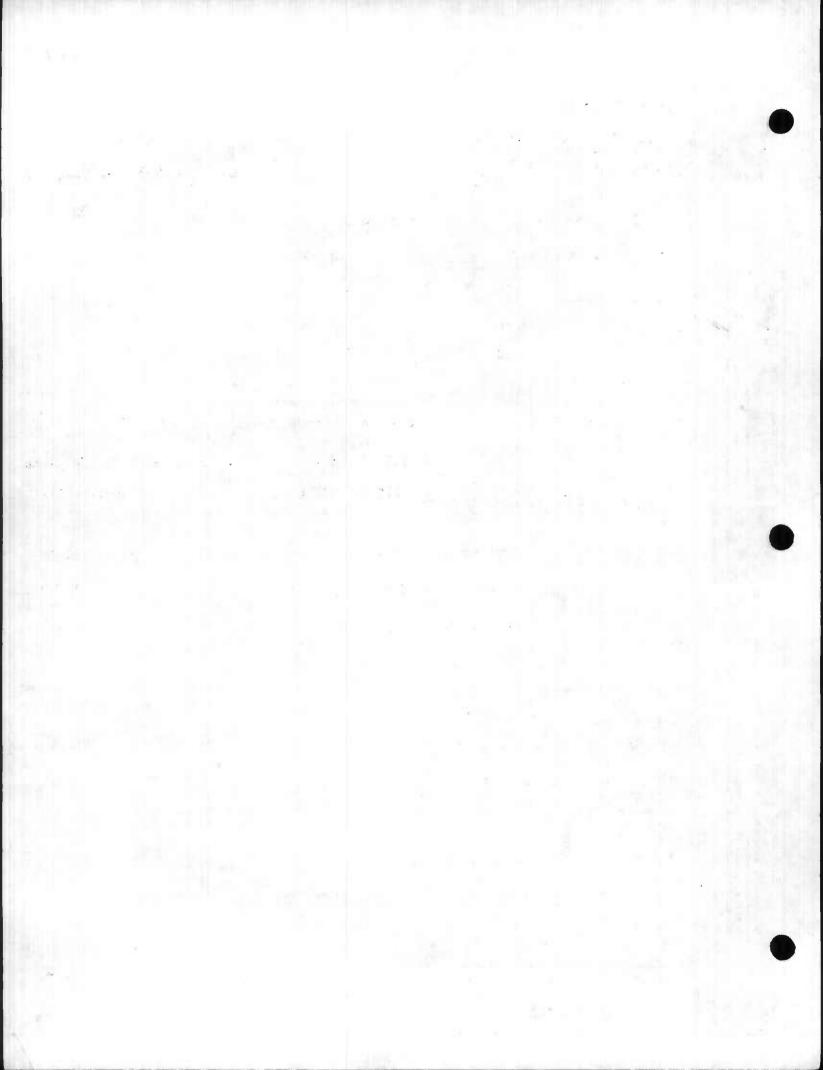
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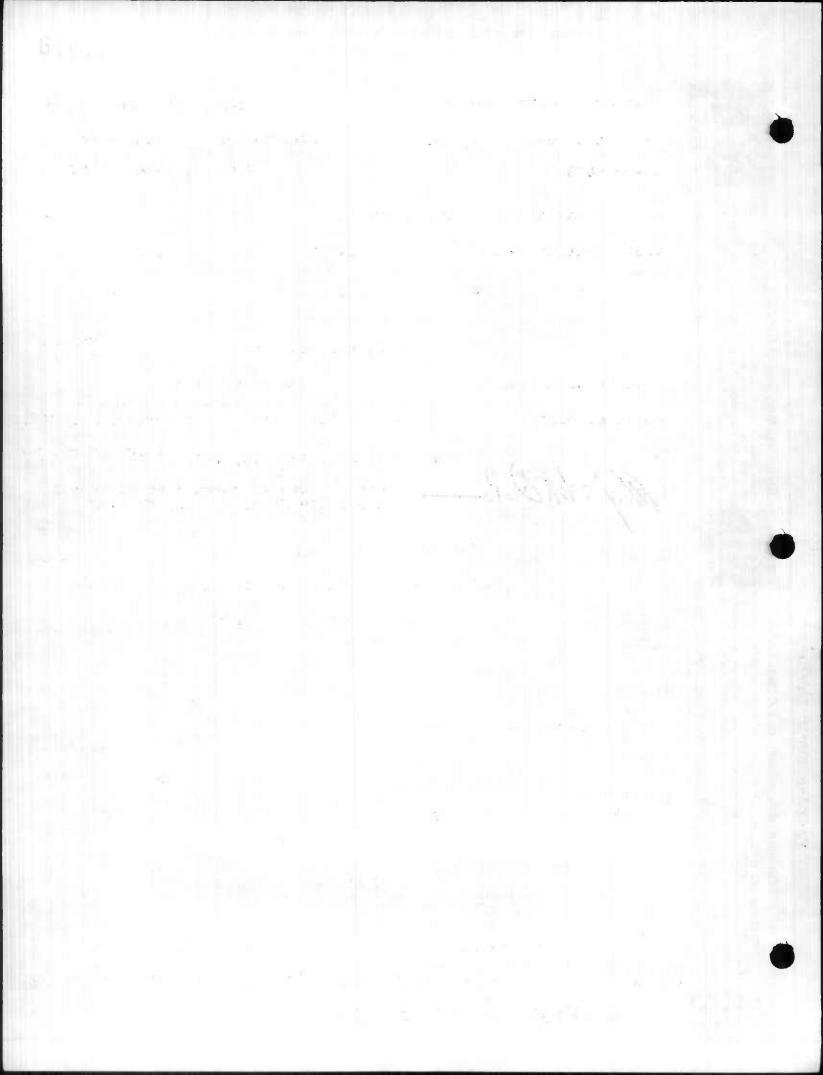


		Certificate of Death	F	Reg. No.	
	Physician /Medical		2. Dete of Dee Month JULY	Dey Year	3. Time of Death
	Examiner	4e Facility Neme (If not institution, give street and number)  4b. City, To	own, or Location of Deeth		
		Washington County Hospital Hage  5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under	erstown 24 Hrs. 8. Date of Birth	Washing	
	Funeral Director	131-28-6073 1 M 2 X 61 Yrs. Months Days Hours Usuel Residence of Decedent	Min. Feb. 4	, 1938 Cou	place (State or Foreign ntry) NY
	Mon	10a. Stete 10b. County 10c. City, Town or Location			10d. Inaide City Limits
	r 28a-f ahow	MD Washington Clear Spring			1 ☐ Yes 2K☐ No
	inter death with the Meryland rines 23a or 28e-f show rines must be notified at Funeral Director	10e. Streef and Number 12013 National Pike 21722	1	U.S.A.	ntry?
21215-0020	urs after at', or its Examine by Fur	3 ☐ Widowed 4 ☐ Divorced Yeer or Detes:	n, Puerto Rican, etc.)	14. Race - Ameri Bleck, White, Specify: Whi	, etc.
5-0	72 ho	15. Decedent's Education 16e. Decedent's Usuel Occupefion (Specify only highest grade completed) (Give kind of work done during mos	at of working	16b. Kind of Business/Ir	ndustry
121	yglene.  yer than "neture  tt, ine Westeel  Completed	Elementery/Secondary (0-12)  12  College (1-4or 5+) College (1-4or 5+) Clerk, service	manager	Food Mark	ket
	EIPE A	17. Fafher's Neme (First, Middle, Last)  18. Mothe	er's Neme (First, Middle,	Meiden Sumeme)	
/lan	Dade m	Vincent L. Talbot Ma	ry Dyanio	ck	
Maryland	nd 2 should lith and Mer 27 is merke r traumetic	19e. Informent's Neme/Relettonship (Type, Print)  Courtney Martin  19b. Meiling Address (Street end Number 12013 National			
Baltimore,	Pages 1 enent of Heemint: If item:	20e. Method of Disposition  1 Burlel 2 Cremetion 3 Removet from Stete  4 Donetion 5 Other (Specify)  20b. Piece of Disposition (Neme of cemetery, cremetory or other piece)  Rose Hill Cem. Jul	Dete y 10, 1999	20c. Location - City or T 9 Clear Sp	
Ball	permit. Page Department of Important: If any Injury or once	21. Signature 1 to hera Service (causes Donald Edwin Donald Edwin	Thompson	Funeral H	Home, Inc
		23a. Part I. Entry the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or man failure. List only one cause on each line.	cardiec or respiretory err	ng, MD 21	Approximete interval Between
	Physician /Medicai Examiner	Immediate Cause (Final disease or condition Condition Condition	aust		Onset and Deeth
		resulting in death)  Due to (or es e consequence of):  Ruke Nyorordal	Puforci	(	hour
	be executed ician end buriel-transit	Sequentielly list conditions,  Due to (or es e consequence of):	0		
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XO					
9. B	0 0 0	Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert II.	i. 23b. Dld t	obacco uae contribute i	to the cause of death?
P.0	that the sed by the deteche		12	ree 2□No 3□Pro	obably 4 Unknown
ds,	requires the seen signed hould be debt		24e. Wes	en eutopsy 24b. V	Vere eutopsy findings
Records,	The law requir sate has been s page 2 should Completed		perfor	rmed?	vailable prior to ompletion of cause f deeth?
	The law ate has be page 2 s		1 D Y		□Yas 2♥No
of Vital	ysician: The k s certificate ha director, page	25. Was case referred to medical 26. Piece	e of Deeth (Check only or		
) t		Hospital:	ursing Home 5 - Fiesd	tenca 6 Other (Speci	ify)
	ng Pt	27. Menner of Death  28e. Date of Injury 28b. Time of 28c. Injury et Work?  Work?  Work?	28d. Describe h	now injury occurred	
Division	r death. ector: After by the fune	2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, fectory, office	281 Location (5	Street and Number or Rui	ral Route Number
Div	tel or Attending P rs effer death.  al Director: After t led in by the funers  Certification:	4 Homicide determined building, etc. (Specify)	City or Tow	m, State)	
	To the Hospital or Attending Phwithin 24 hours effer death. To the Funeral Director: After this completely filled in by the funeral Medical Certification:	29a. Certifier (Check only one)  29a. Certifier (Check only one)  Medical Examinar: On the best of my knowledge, deeth occurred et the time, date en end manner stated.  end manner stated.	nd plece, end due to the costh occurred at the time, o	ceuse(s) end menner as dete end pieca, and due	stated. to the cause(s)
	within To the comple	29b. Signature and title of certifier 29c. License number		29d. Date signed (Month	, Dey, Year)
		May F. There my . D 198	524	July 7, 189	9
		30; Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print) SUNA F. SUNA 366 Mill 87.	Hagus	form Kg	2217KD
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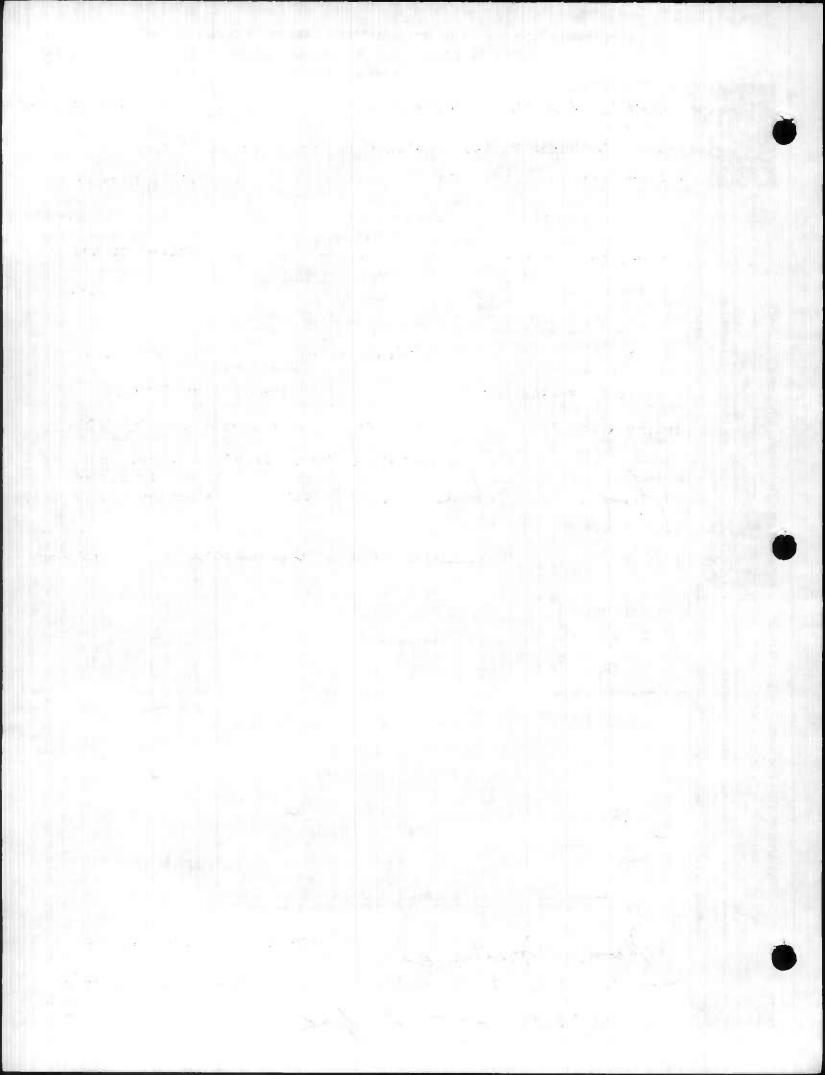
BARBARA MARTE MARTEN



State of Maryland / Department of Health and Mental Hygiene 99 21,079

						Certifica	ate of	Death		Reg. No.		/
	Physician - /Medical	1. Decedent's Nar	me (First, Middle, La PIE EV	ELYN	MAK	ZTIN			2. Date of D Month	Day	Year	Time of Death
	Examiner	4e Fecility Name	(If not institution, giv	e street and number)				4b. City, Town, o	Location of Dea	th 4c. County	of Deeth	
-	Funeral	Carroll 5. Social Security	Number 6. S		ge Hea	1th Cantholay) If Uni	der 1 Yeer	Westmi Hours Mir	nster s. 8. Date of B (Month, D	irth Cari	9. Birthplace (	(State or Foreign
	Director	213-09- Usual Residence	ot Decedent	□ M 2√F	88	Yrs.	04/3	110010		3,1910	Maryla	
	nylen ihow	10e. State	10b. County		10c. City, Tow							side City Limits
	Be-f	MD	Carro:	L 1	Wes	tminst				T	- 21	Nes 2□No
	th with the Mar 23a or 28a-f al at be notified al Director		umber Luke C:	ircle			Zip Code 21158	3		United		S
21215-0020	filed within 72 hours after death with the Marylend Hygiene. ther than "natural", or items 23s or 28s-1 show int, the Medical Examiner must be notified at int. The Medical Examiner must be notified at S. Completed by Funeral Director	3 ☐ Widowed	rried 2 Married 4 Divorced	12. Wes Decedent Armed Forces? 1  Yes 2  If Yes, Give Yeer or Dates:			cedent of I pecify Cub 2 No	Hispenic Origin? ( lan, Mexican, Pue Specify:	Specify Yes or Norto Rican, etc.)	lo- 14. Rad Ble Specif	ca - American Ind ck, White, etc. y: Whi	
5-0	d 2 should be filed within 72 hours th and Mentel Hygiena. 7 is marked other than "natural; traumatic event, the Medical Exa To Be Completed by	(Spe	15. Decedent'a Ed	ducation ide completed)	16a	Decedent's U	sual Occu work done	pation during most of w id)	orking	16b. Kind of B	usiness/Industry	
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	/Medical   Examiner	Immediate Cause disease or conditi	ion	A A2	ZHE	EIME	215	DE	トールの	A	10	Yonzo
9)	EXPLEMANT.	resulting In death	)		Due to (or es a	consequence	ot):					
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P.O.	that the death certined by the attending detached for use a Physician/M	Part II. Other sign	inteant conditions o	ontributing to death be	ut not resulting i	n the underlyin	g cause gi	ven in Pert I.		d tobacco uae co	3 Probably	
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ion	Attending is death. ector: Atterby the fune	1	5 Pending investigation	(Month, Day	y rear)	Injury M		Yes 2 No				
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	To the Hospital within 24 hours a To the Funeral Completely lilled	29a. Certifier (Check only one)		ysician: To the best of ninsr: On the bests of and manner sta	exemination er							
	within To the comp	29b. Signatura	d title of certifier	52 0				se number D17040		29d. Date signed July 19	ed (Month, Day, 9, 1999	
		30 Name and add	dress of nerson w	completed ceuse of d	eath (Item 23a)	(Type Print)						
			G. Lania	-			ton	Hats Me	d'l c+	r, West	tminsta	er. MD
	State	31. Dete tiled (Mo			ar's Signature	Dirting	COII	ing co me		L, WES		21157
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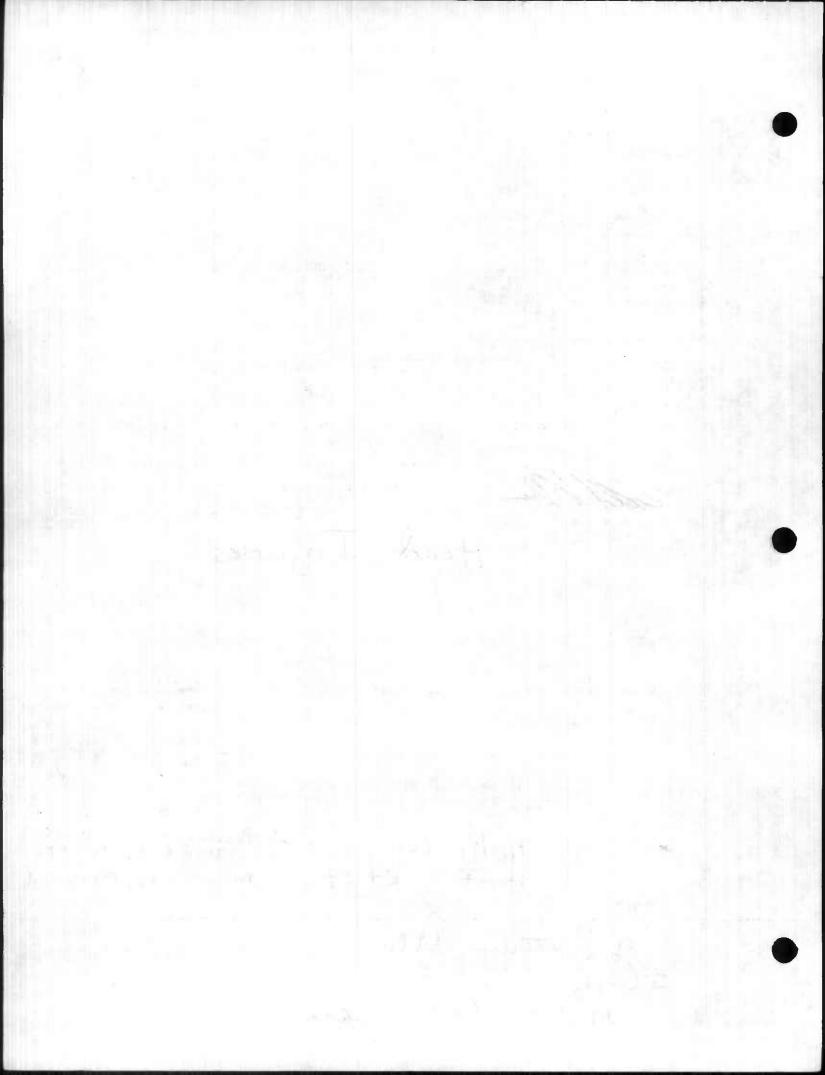


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E	/Medical	Braden Dougla		number)			4b. City, Town, or	JULY Location of Dea		1999 ounty of Death	0023 AM
	Examiner	ROUTE#27 @					MT.AIR			ARROLL	
	Funeral	5. Sociel Security Number	8. Sex		. last birthday)	If Under 1 Yeer Months Days	If Under 24 Hrs Hours Min		irth	9. Birth	place (State or Foreign
	Director	190-64-6938	1 1 M 2 □ F	18	Yrs.	MONINS Days	Hours			80 Mary	
pue		Usuel Residence of Decedent 10a. Stete 10b. Co.		10c. C	ity, Town or Lo	cation					10d. Inside City Limits
Mary	f show	Maryland Carr									1 ☐ Yes A R No
the the	or 28a-fa be notified Director	10e. Street and Number	OII	WES	tminste	10f. Zip Code			10g. Citize	on of Whet Cour	ntry?
th with	23a o	2324 Beren La	ıne			21157			Unite	d State	s
11215-0020 within 72 hours after death with the Manyland	iene. Than "natural", or Itama 23a or 28a-f ahov the Medical Examiner must be notified at ompleted by Funeral Director	11. Meritel Status	12. Was D	ecedent Ever in U Forces?	U,S. 13.	Ves Decedent of H Yes, specify Cub	lispanic Origin? ( an, Mexican, Pue	Specify Yes or N rto Rican, etc.)	lo- 14	Black, White,	
20 20	y Fi	1 Never Merried 2 □ 3 □ Widowed 4 □ Divo	If Yes,			□ Yes 20 No	Specify:		S	pecity: Whi	te
Maryland 21215-0020	tal Hygiene. I other than "natural", o event, the Wedfral Exer Be Completed by		edent's Education	r Detes:	16a Dece	lent's Usual Occup	nation		16b. Kind	of Business/In	dustry
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be filed	d other event,	17. Father's Neme (First, Mid	idie, Last)				18. Mother's Ne	me (First, Middl	e, Maiden Si	umame)	
Sould bloom	o and Mental Hygie Is marked other ti raumatic event, to To Be Col	Gregory L. Ma					Barbara				
, Mal		19e. Informent's Neme/Relet			100	g Address (Street					Code)
re i	ILD	Gregory Mann 20a. Method of Disposition	(Father)	20b.	Ptece of Dispo	Beren Lansition (Name of		minster. Dete		115 / ation - City or To	own, Stete
altimore,	ont of rt: # H ry or o	to Burial 2 ☐ Cremeti		m Steta		natory or other pla st Memor:		7/10/00	Cla	omfiold	T) A
Balti Permit.		21. Signeture of Funerel Serv		JOIN	22	. Neme end Addre	ss of Fecility				• PA
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		23a. Pert1. Enter the diseese shock, or heert leilure.	e, or complications the	ot caused the dee	oth. Do not ent	er the mode of dyin	ng, such es cardie	c or respiratory	arrest,	ra, MD	21784 Approximete Intervel Between
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DIVISION or Attending	rs after death.  at Director: After tied in by the funer.  Certification:	4 ☐ Homicide de	termined bu	ilding, etc. (Speci	ify)	eet, fectory, office		City or T	own, Stere)	~ IV	10 - 10 m
spita	meral filled	29a. Certifier 1 Certi	ifying Phyelcian: To	he best of my kn	owledge, deeth	occurred et the til	me, date end plac	11	e cause(s) a	nd manner as s	stated.
H D	within 24 hours after To the Funeral Dire completely filled in t Medical Certi		Ical Examiner: On the								
Tott	To the comp	29b. Signeture and title of cer	nitier		108	29c. Licens			29d. Date	signed (Month,	Day, Year)
		7	ester	u-, (	MI	0.	C.M.E		JUL	Y 14, 1	.999
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State Registrar

31. Dete filed (Month, Day, Year) JUL 1 6 1999

32. Registrar's Signeture



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** 3:30 A.M. JULY 17 1999 CORA MAE NETHERTON /Medical 4e. Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner SOLOMONS CALVERT SOLOMONS NURSING CENTER If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. lest birthdey) If Under 1 Year Birthplaca (Stete or Foreign Country) **Funeral** Months Deys 577 18 3827 1□M 2⊠F 81 March 30, 1918 WashingtonDC Director Usuel Residence of Decedent 10e Stete 10b. County 10c. City, Town or Location 10d. inside City Limits 28a-f show the Medical Examiner must be notfled at Director MD P.G. Upper Marlboro 1 ☐ Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 5914 Old Croom Station Road Herne 23a 20772 United States 14. Rece - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☐ Married 3altimore, Maryland 21215-0020 natural, or 1 ☐ Yes 2 ☐ No Specify: À Specify: White 3. Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry el Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 9 permit. Peges 1 and 2 should be life Department of Health and Mentel Hy Important: If Item 27 Is marked othe any injury or other traumatic svent, once. 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Surneme) Be Charles Walker Elleanora Minder 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 5918 Old Croom Station Road, Upper Marlboro, MD John Netherton (SON) 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) July 20, 1999 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Buriai 2 ☐ Cremetion 3 ☐ Removei from State Maryland Veterans Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) Cheltenham, Maryland 22. Name and Address of Facility LEE FUNERAL HOME, INC. 21. Signeture of Funerei Service Licensee 6633 OLD ALEXANDER FERRY RD. CLINTON. 20735 allee MD 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart feilure. List only one cause on aech line. Approximate Interval Between Onset and Deeth Physician /Medical tmmediete Cause (Finei CEREBRO VASCULAR ACCIDENT diseese or condition resulting in deeth) Examiner Due to (or es e consequence of): Examiner physician and s the buriel-transit The law requires that the death certificete be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Lest Due to (or es a consequence of): Box 68760. Physician/Medical Due to (or es e consequenca of) P.O. Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by MAINUTRITTON, CHRONIC RENTAL PAILURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, à CONGESTIVE FASTICT PAILURE, CORONARY ARTERY OUS OFFE Performed? 24b. Were sutopsy findings evallable prior to completion of cause of deeth? Be Completed page CAS, HYPOTHYROIDSM, MR PYD, BKA 1 Yes 2 No 1 ☐ Yes 2 12 No certificate Division of Vital Hospital or Attending Physician: 25. Wes case referred to medical exeminer? 26. Piace of Deeth (Check only one) Hospitei: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 2 iours effer death.

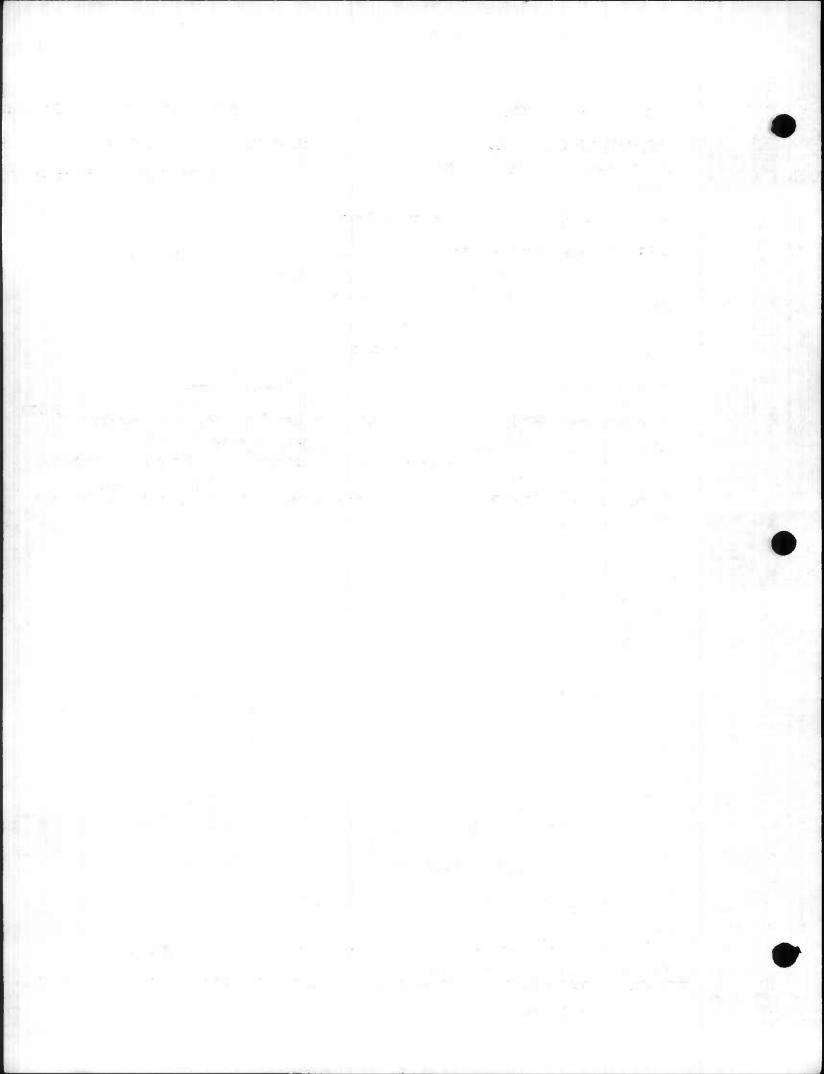
neral Director: After this if filled in by the luneral di 27. Menner of Death 28a. Dete of injury (Month, Dev Year) 28c. tnjury et Work? Certification: 28d. Describe how injury occurred 1 Netural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ SuicIde 28e. Pieca of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital of within 24 hours of To the Funeral D completely filled. 10 Certifying Physictan: To the best of my knowledge, deeth occurred at the time, dete end piece, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and piece, and due to the cause(s) and menner stated. edical 29e. Certifier (Check only one) 29b. Squature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) JULY 19, 1999 30. Name end eddress of person who completed cause of death (item 23a) (Type, Print)

ID State Registrar

31. Dete filed (Month, Day, Year) 32. Registrar's Signeture JUL 2 1 1999 Gener

FULTON P. LUKBAN, M.D. 135 W. DARES BEACH RD. SUITE 109 PRINCE FREDERICK, MD

20678



WILLIAM

Please Type or Print in Bla	ck Indelible ink. Assure A	III Copies A	re L	egible.	
State of Maryland /	Department of Health and I Certificate of Death		ene i	99	24082
1. Decedent's Name (First, Middle, Last) William Kenneth Naughton		2. Date of Death Month JULY	Day 8,	Year 1999	3. Time of Dec 2:54A . M

If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min.

8. Date of Birth (Month, Day, Ye July 26

2:54A.M.

9. Birthplace (State or Foreign Country)
Washington DC

4c. County of Death CALVERT

4b. City, Town, or Location of Death

PRINCE FREDERICK

NAU	IGHTON
	Physician
	/Medical
2010	Evaminar

4a Facility Name (If not institution, give street and number)

CALVERT MEMORIAL HOSPITAL

5. Social Security Number

**Funeral** Director

pemit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hyslene. Important: If item 27 is marked other then "netural", or items 23s or 28s-f show eny injury or other traumatic avent, the Medical Examiner must be notified at 0008.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

To the Hospital or Attanding Physicien: The law requires that the death certificate be executed within 24 hours after death.

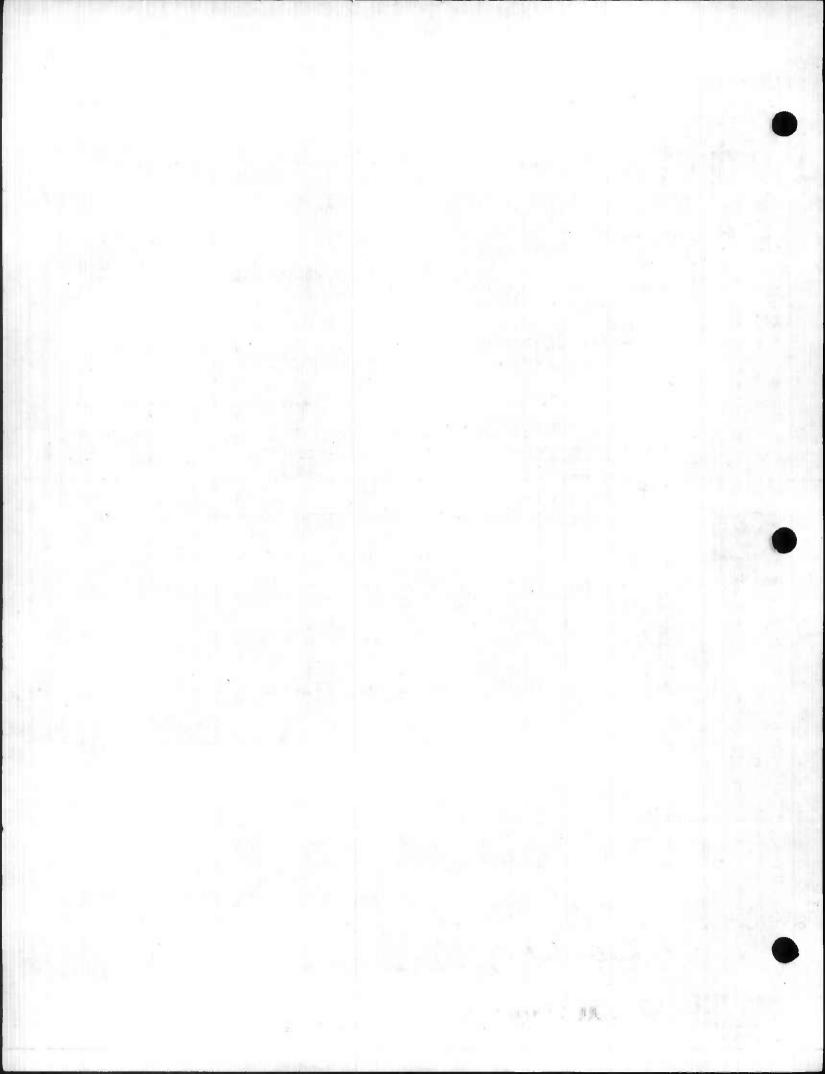
To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be deteched for use as the burle-transit

Division of Vital Records, P.O. Box 68760,

5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Months [	Year If Uni	der 24 Hrs.	8. Date of Bir (Month, Da	th	9. Birthplace (S Country)	State or Foreign
212 66 6407	1⊠M 2□ F	44	Yrs.	TOTAL TO T	1100		July :	26 1954	Washi	ngton
Usual Residence of Decedent  10s. State 10b. County		10c. Ci	ty, Town or Loc	cation					10d. Ins	ide City Limits
Maryland Calv	ert		śby							Yes 2 No
10e. Street and Number 954 Crystal	Rock Ro	ad		101. Zip Ci 206				10g. Citizen of V Unite	What Country? ed Stat	es
10e. Street and Number 954 Crystal 11. Marital Status 1 Never Married 2 Man 3 Widowed 4 Divorced (Specify only higher Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, William T. N	Armed F	2 No	If	Vas Deceder Yes, specify	Cuban, Mex	ican, Puerto I	city Yes or No Rican, etc.)	Blac	e - American Ind ok, White, etc. o: White	an,
15. Deceden	'a Education		(Give I	ent'a Usual (	done during n	nost of working	ng	16b. Kind of Ba	usiness/Industry	
Elementary/Secondary (0-12)	Cottege	(1-4or 5+)		O NOT use				Safev	12.11	
17. Father's Name (First, Middle, William T. N			Retai	.1 (1	18. Mg		(First, Middle Y J .	Maiden Suman	-	
19a. Informant's Neme/Relations Sandra L. Nau		wife				mber or Rura		er, City or Town, MD 2065		
20a. Method of Disposition  1 ABurial 2 Cremation 4 Donation 5 Other (S)	3 Removal from	20b. I	Place of Dispos cemetery, crem uthern	atory or other	TPEPT V	10 td	1999 ens	20c. Location -	City or Town, SI	
21. Signature of Funerel Service					Address of Fa	Rau	sch F	uneral	Home I	PA
23a. Part1. Enter the disease, or	och		440	)5 Br	oomes	Is.	Rd. P	ort RE	oublic	MD 206
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Part II. Other significant conditions	c		or as a consequ							
Part II. Other significant condition	ns contributing to	death but not res	sulting in the un	derivina cau	se given in Pa	art I.	23b. Dld	tobacco use co	ntribute to the c	ause of death?
	•							Yes 2 No	3% Probably	
							perfe	en eutopsy ormed? ECTION	24b. Were au available completi of death?	prior to on of cause
							10	Yes 2 No	1 🗆 Yes	2□ No
25. Was case referred to medical examiner?	44					tace of Death	(Check only	one)		
Yas 2 No			ER/Outpatient			-		idence 6 Oth		
27. Manner of Death 1 Natural 5 Pendin 2 Accident investig	pation	of Injury nth, Dey Year)	28b. Time of Injury	M 280	Injury at Work? 1 ☐ Yes 2		28d. Describe	how injury occur	red	
3 Suicide 6 Could a determined	inad 288. Plac	e of Injury - At h ding, etc. (Special		et, factory, o	ffica	2	28f. Location ( City or To	Street end Numb wn, State)	per or Rural Rout	e Number,
	g Physician: To th Examiner: On the I and ma									ause(s)
27. Manner of Death    Death	11 Vi	our &	6B.		icense numb			29d. Date signe	d (Month, Day, ) 999	(ear)
30. Name and address of person Theodore King M		of death (Iter			nn Str	eet, B	altimo	re, Mary	vland 21	201
31. Date filed (Month, Day, Year)	1 <b>6 199</b> 9	Registrar's Signa	ature	6	la					

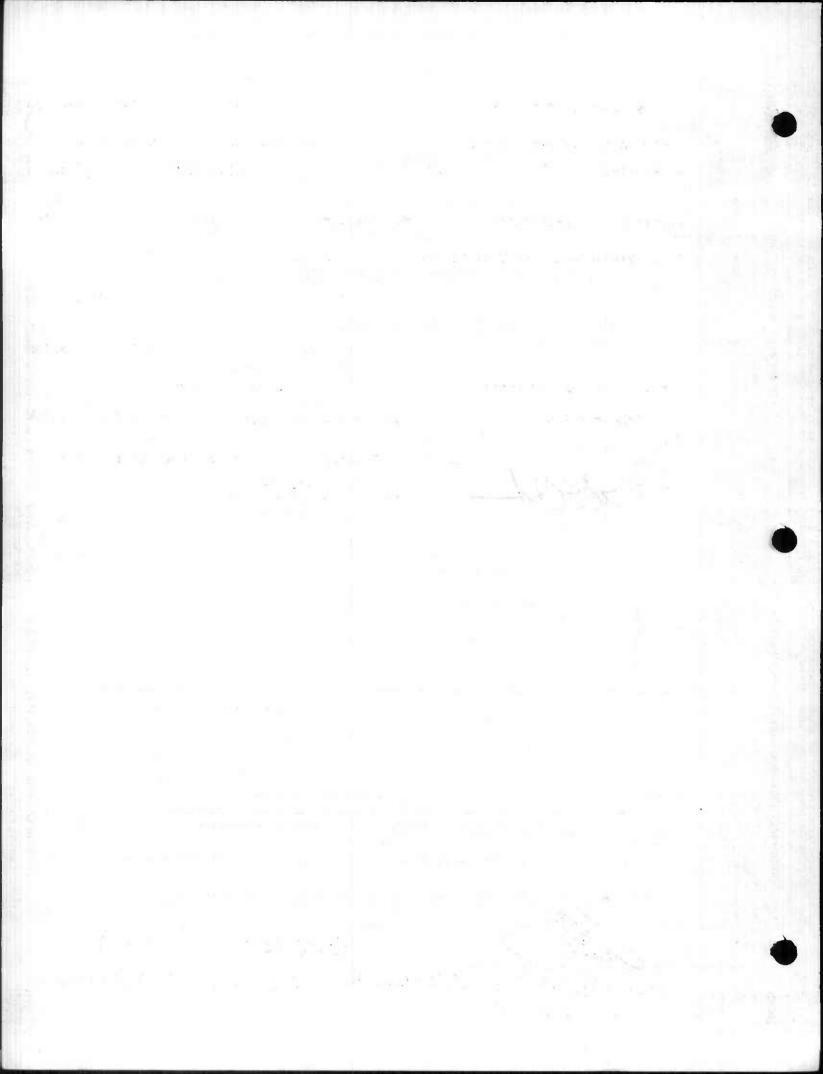
**DHMH 16 Rev 6/95** 

Stat Registra



State of Maryland / Department of Health and Mental Hygiene 99 24083

						Certif	ficate of	Death		Reg. No.	2	. 4 (	
		3	1. Decedant's Nama (First, Middla, La	st)					2. Data of I		V	3. Tim	na of Death
	Physici /Medic		Roy Lee Ornd	orff, Sr.					July	28	1999	3:	:45 am
)	Examir		4a. Facility Name (If not institution, giv	e street and number)				4b. City, Town,	or Location of De	ath 4c. Count	y of Death		
			Homewood Retire		r				msport		shing		
0	Funeral		5. Social Security Number 6. S	ax 7. Age ØM 2□ F	(In yrs. last bii	N	If Undar 1 Yaar Months Deys		in. 3. Date of E	Birth Day, Year)	9. Birthpl	ace (State)	ate or Foraign
	Director		718-18-7821  Usual Rasidance of Decedant	A	. 94	Yrs.			July 2	6,1904	VI	rgir	119
	pue *		10a. Stata 10b. County		10c. City, Tow	n or Locati	ion				10	Od. Insid	a City Limits
	Mary	ō	Maryland Was	hington		Will	iamspor	<b>^</b> +					Yes XXNo
	the	Director	10e. Street and Number				10f. Zip Coda	•		10g. Citizan of	What Coun	try?	
	3a o		16505 Virginia Av	enue Cotta	ne #214	i		21795		US			
	me 2	Funeral	11. Marital Stetus	12. Was Decedent Ev				Hispanic Origin? ben, Maxicen, Pu	(Spacify Yes or I		ce - America		n,
0	or he		1 Never Merried 20 Marriad	Armed Forcas?					arto Hican, atc.)		ck, White,		
00	hours efter death with the Marylend nuref, or flems 23a or 28s-f show at Examinet must be incitited at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Giva Yaar or Datas:		10	Yas 2⊠ No	Specify:		Speci	ry: W	hite	9
Maryland 21215-0020	be filed within 72 hours efter death with the Marylen tal thygiene. d other than "naturel", or flems 23s or 28s-f show event, the Medical Examiner must be profited at	Completed	15. Decedant's Ed (Specify only highast gra	ducetion da completed)	16a.	(Giva kine	t's Usual Occu	during most of v	vorkina	16b. Kind of 8	Business/Ind	lustry	
121	within 72 ene. than "nat	idu	Elamentary/Secondary (0-12)	Collega (1-4or 5+	)	lifa. DO	NOT usa ratin			Sanitat	+: C		
2	Hygie ther ther ther the	ပိ	12 17. Fathar's Name (First, Middla, Last)	4			Direc	_	lomo /First thirds			OIIIIII	1551011
and	ntal h	Be		Orndorff						la, Meidan Suma	maj		
7	2 should be filed withli and Mental Hygiene. Is marked other than sumatic event, the M	ပို	Joseph William  19a. Informant's Name/Relationship (		106	Malling 4	Addraga (Otros	Lau		Snyder  ober, City or Town	Otato Zin	Codel	
	ges 1 end 2 should t of Health and Mer if item 27 is marks or other treumatic		John Orndorff/Son							Lake, Ne			12019
re,	Health tem 27		20a. Mathod of Disposition		20b. Place o	f Disposition	on (Name of		Data	20c. Location			e
9	age ent of rt: If i		1X Burial 2 ☐ Crametion 3 ☐ 4 ☐ Donation 5 ☐ Othar (Specific				ory or other pla Cemeter		7-23-00	Buena \	licta	Vir	ninia
Baltimore,	permit. Pages 1 end 2 Department of Health a Important: If item 27 is any injury or other tre		21. Signature of Funaral Service Licen		OI CCIII					Duena	1310,	V 11 5	311110
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	Physician	1	STOCK, or naart failure. List only	ona ceusa on each lina							0	Onest a	Between and Deeth
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E .	The ate h	Completed	Hundarion,						10	Yas 2 No	1□	Yes	2□ No
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of	Physicien: this certific ral director,	To	1 ☐ Yas 20 No	Hospital: 1 ☐ Inpatiant	2 ER/OL	tpatient	3LI DOA		Homa 5□Ra	sidence 6 🗆 Ot	har (Specify	)	
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Sic	Attending or death.	cat	2 Accidant Investigation 3 Sulcida 6 Could not be		1			]Yas 2□No	004 1	/O++/ A/		10	A4
Division	5 # 5 =	Certification:	4 ☐ Homicida determined	28a. Place of Injury building, atc.	y - At noma, ta (Specify)	ım, streat,	, ractory, office			(Street and Nurr own, State)	iber or Hura	Houta	vumber,
_	Hospital 24 hours Funerel stely filled		29e. Cartifier 127 Certifying Phy	ysician: To the best of	my knowledge	deeth oc	curred at the t	ima data and nis	ice and due to th	a causa(s) and n	enner as st	nted	
	To the Hospital or within 24 hours after To the Funerel Dir completely filled in	edicai		iner: On the basis of a	xamination an	d/or Invast	tigation, in my	opinion, daath oo	curred at tha time	a, data and place	, end due to	the ceu	se(s)
	To the within 2 To the comple	Me	29b. Signatura and the of continue				29c. Lican	sa number		29d. Date sign	ed (Manth, I	Эау, Үөг	ar)
3			1/1/1/3	- )			D	26 FC	21	7/	21/13	7	
			30. Nema end address of person who	completed ceuse of das	ith (Itam 23a)	(Type, Prin	nt) 1	,1	,				
			Alia Now	747	NOH	ton	Nie	1/00	Now	- on	151	74	5
	Sta		31. Deta filed (Month, Day, Year)	32. Registrar	s Signatura	4	1.	,					
	Registr	ar	JUL 2 2 199	J / P'		. 1	your						



WRC Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. 99-4271-043 24084 State of Maryland / Department of Health and Mental Hygiene 99 WILLIAM R. PALMER Certificate of Death : #23 PART I 27 PER MEO G774 8-11-99 WR. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death JULY 20, Dey 1999 **Physician** 10:24 AM. William Richard PALMER /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON COUNTY HOSPITAL HAGERSTOWN Washington If Under 1 Ye If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 10 M 20 F 46 Director 220-58-3143 Dec. 4 1952 Maryland Usual Residence of Deced with the Maryland 10a. Stete 10b. County 10c. City, Town or Location ahow 10d. Inside City Limits mast be notified at 1 ☐ Yes 2 ☑ No Directo Hagerstown Maryland Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16124 Broadfording Road 21740 U.S.A. Funerai death Neme ; 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-th Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indien, Pages 1 and 2 ahould be filled within 72 hours after d nent of Health and Mental Hygiene. ant: If Nem 27 is marked other than "natural", or Iden ury or other traumatic avent, the Medical Examina. Bleck, Whita, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married 21215-0020 Specify: White 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Delivery Person Donut Shop 12 Baitimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Lola May Reickard Luther David Palmer 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Patsy Ann Palmer - Wife 16124 Broadfording Road Hagerstown, Md. 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stata 1 X Burial 2 ☐ Cremation 3 ☐ Removel from State Department of important: If any injury or pace. 4 ☐ Donetion 5 ☐ Other (Specify) Rest Haven Cemetery 7/23/99 Hagerstown, Maryland 22. Name and Address of Fecility 21. Signeture of Funeral Service Licenses Minnich Funeral Home COUPI 415 E. Wilson Blvd. Hagerstown, Md. 21740 23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete intervel Between Onset and Death **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Examiner Due to (or as a consequence of): Examine The law requires that the death certificate be assecuted burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or Injury that initialed events resulting in death) Last pug Due to (or as a consequence of) Box 68760. physiclan Physician/Medicai the Due to (or as a consequence of) 88 980 signed by the at d be detached for Perf II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert t. P.O. Records, by 24a. Was an eutopsy performed? Completed peeu page 2 certificate has Yas 2 No 86

of Vitai Physician: Division Attending

23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveilable prior to completion of cause of death? 1 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) XXYes 2□ No 1 Inpatient 2XXXER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stele) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check or cone)

State Registrar

Certification: To

Medical

29b. Signature

30. No

this funeral

After

death.

ò

after death the

24 hours Funeral

To the within 2

med in by

31. Date filed (Month, Day, Year) Registrer's Signature

2 2 1999

d cause of pleath (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

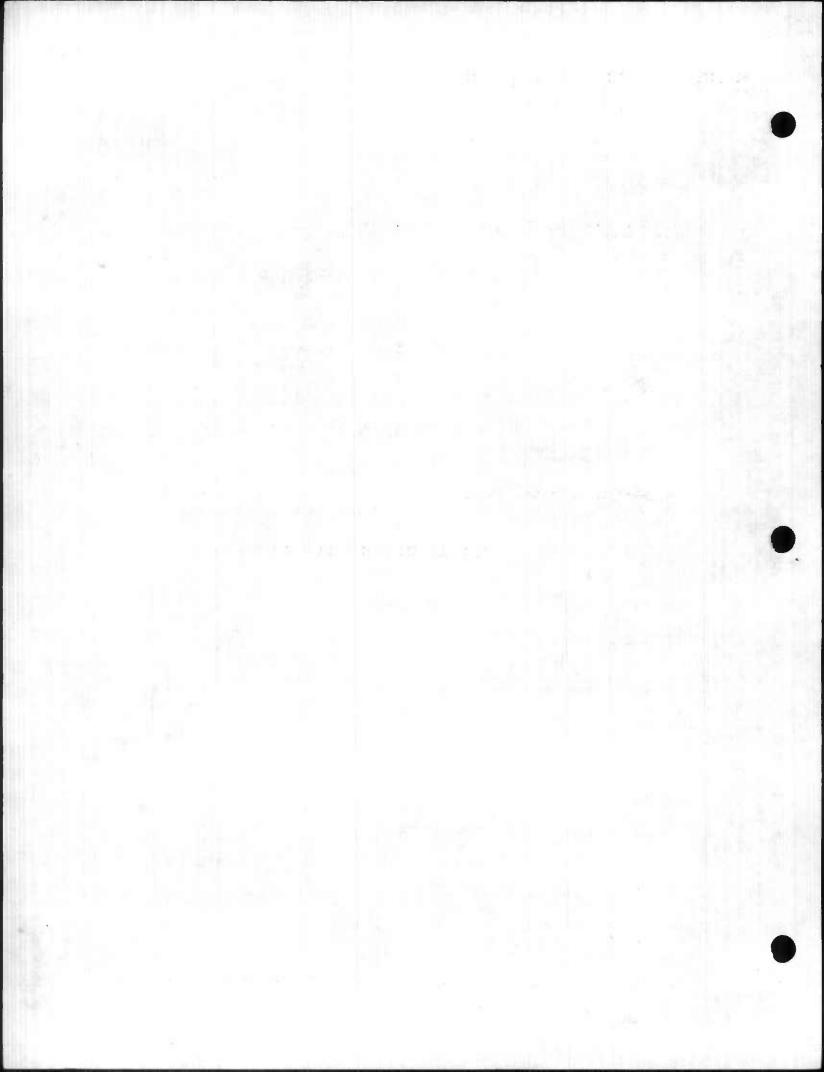
29d. Dete signed (Month, Day, Year)

JULY 21, 1999

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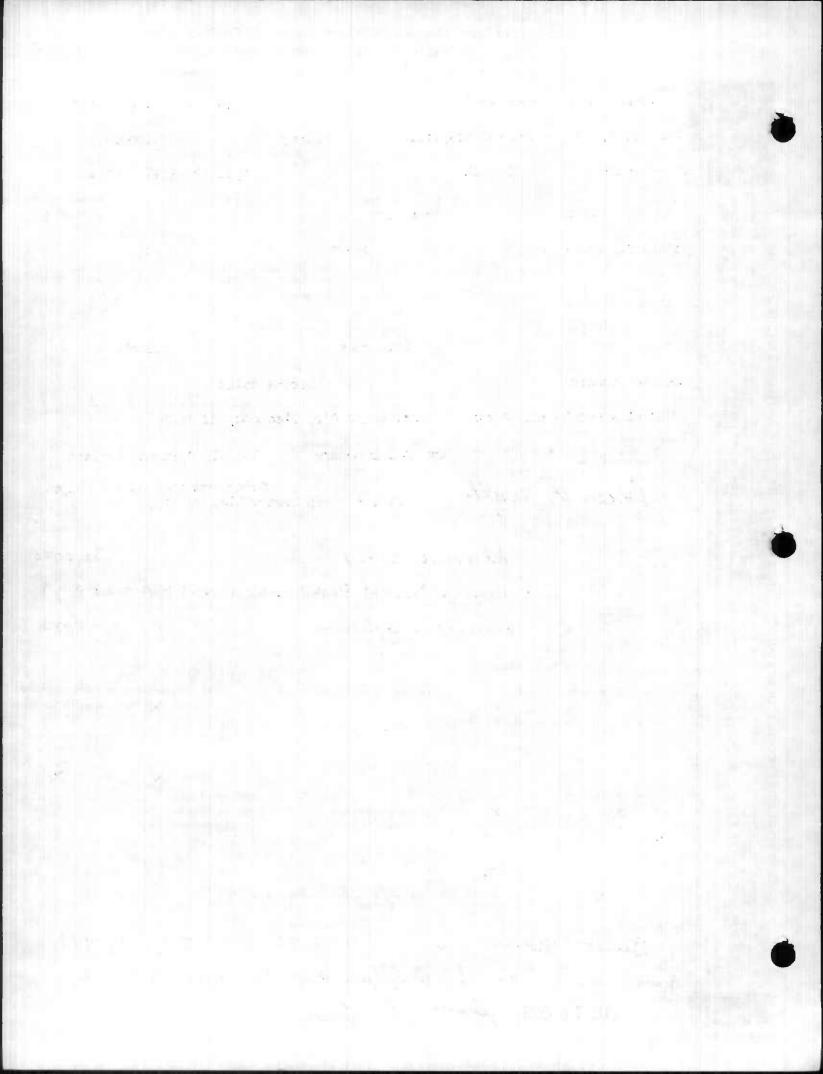
29c. License number

O.C.M.E.



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 24085 Certificate of Death

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Physician /Medical	1	1. Decedent's Nam Irene			odwois	ski						2. Date of D Month July	14	ay 199	Year 99	3. Time of 1720	Death
Examiner	, 4	a Facility Name (i Montgome					nital				City, Town, or	Location of Des		c. County			
					-		•		If Under 1 Yea		If Under 24 Hrs	100.40		ontg			
Funeral Director	3	5. Social Security N 361–44–00	14	6. Sex	2 XF 7.	82	yrs. last bir	Yrs.	Months Day:		Hours Min		28 1	917	Ind:	plece (Stete ontry) iana	vr Foreign
P	- 1	Usual Residence of 10a. State	10b. County			10c	. City, Tow	n or Loca	ation							10d. inside Ci	ity Limits
e Maryla la-f sho tifed at		Md	Howard	ł			Mount									1 🗆 Yes	
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r items 23s	5	11. Meritel Stetus		12.	Was Decede	ent Ever	in U,S.	13. W	as Decedent of	His	panic Origin? (	Specify Yes or Norto Rican, etc.)	lo-			can Indian,	
72 hours after natural, or its acel Esonine	2 6	1 ☐ Never Marr		ied	Armed Force 1 Yes 2 If Yes, Give Year or Date	No No			Yes, specify Cu □ Yes 2🎇 No		Specify:	no Hican, etc.)			white,		
tura f		- 11	15. Decedent	's Educati		00.	168	Decede	nt's Usual Occ	บกลา	ion		16b. 1	Kind of Bu	siness/Ir	ndustry	
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ed within 72 hours aft sylena.  For than "natural", or the Wall and the Completed by E	5	Elementary/Seco	ondary (0-12)		College (1-4	4or 5+)			emaker					domes	stic		
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/Medical		Immediate Cause disease or condition	(Final		Ad	40	un i C	TI	05						1	3 wee	KS
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death death death		Part II. Other signit	licant conditio	ne contrib	outing to deat	th but not	resulting l	n the und	derlying cause (	aive	n in Part I.	23b. Di	d tobacc	o use cor	tribute 1	to the cause	of death
bet the death dby the attended for physicial				.,,										2 XNo	3 □ Pro		Unknow
he law requires the law requires the has been signed age 2 should be completed by												24a. Wa	s an aut	opsy	24b. V	Vere autopsy vailable prior	tindings
) > 11 W												per	formed?		C	ompletion of death?	
ysician: The law requires secrificate has been signector, page 2 should												10	Yes	2 No			(No
- F # 6 C		25. Was case refer	rad to madical								00 8118			230110		L 165 21	6.10
Physician: this certific ral director,	3	examiner?	,	Hos	pital:				-53-0-10	Othe	r.	eath (Check only		. 🗆	40		
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DIVISION OF that or Attending Physics after death. all Director: After this led in by the funeral of Certification: To		3 ☐ Suicide 4 ☐ Homicide	6 Could r determ	not be ined		f Injury -		ırm, stre	et, factory, offic	a			(Street o		er or Ru	ral Route Nun	nber,
oral C	2	00 0 18		-													
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	3	29a. Certifier (Check only one)	2 Medical	g Physici Examiner	an: To the be On the basi and manne	is of exar	knowledge nination an	deeth o	occurred et the estigation, in my	time y opi	e, date end pled inion, death occ	e, and due to the curred at the time	e cause e, dete e	s) and ma nd plece, a	and due	stated. to the cause(:	s)
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	- 1	30. Name end addr Bennett			190/ C	of deeth	(Item 23a) / - Sau	(Type, P	spring 1	Re	ad, Oln	ey, Mai	rylai	el, 2	208	32	
State		31. Dete tiled (Mon	th, Day, Year)	J	32. Heg	girtrer's S	igneture	1	,								
Registrar			JUL 1 5	1999	9	Jenes	ممر	B.	Spa	uk	2/						



Physician /Medical Examiner

**Physician** 

Examiner

**Funeral** 

Director

28a-f show

Directo

Funeral

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Completed

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than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

other traumatic event,

permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any Injury or other traum DDCs.

12 should be finance in and Mental Finance in an inches of the inches of

the Maryland

filed within 72 hours after death Hyglene.

Maryland 21215-0020

/Medical

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Box 68760

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Division of Vital

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Physician:

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• Funeral Director: A sletaly filled in by the fi

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29a. Certifier

(Check only one)

Examiner Physician/Medicai þ Completed Be 10 Certification:

25. Was case referred to medical axaminer? 1 Yea 25 No 27. Menner of Deeth

> 1 Neturel 2 Accident 6 ☐ Could not be determined 3 Sulcide

28e. Placa of injury - At home, farm, straet, factory, office building, etc. (Specify)

2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted.

29c. Licansa number

28f. Location (Street end Number or Rurel Routa Number, City or Town, Stete) XIX Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end pleca, and due to the cause(s) and manner as stated

29b. Signatura and title of certifiar

D28352

29d. Dete signed (Month, Dey, Year)

JULY 21. 1999

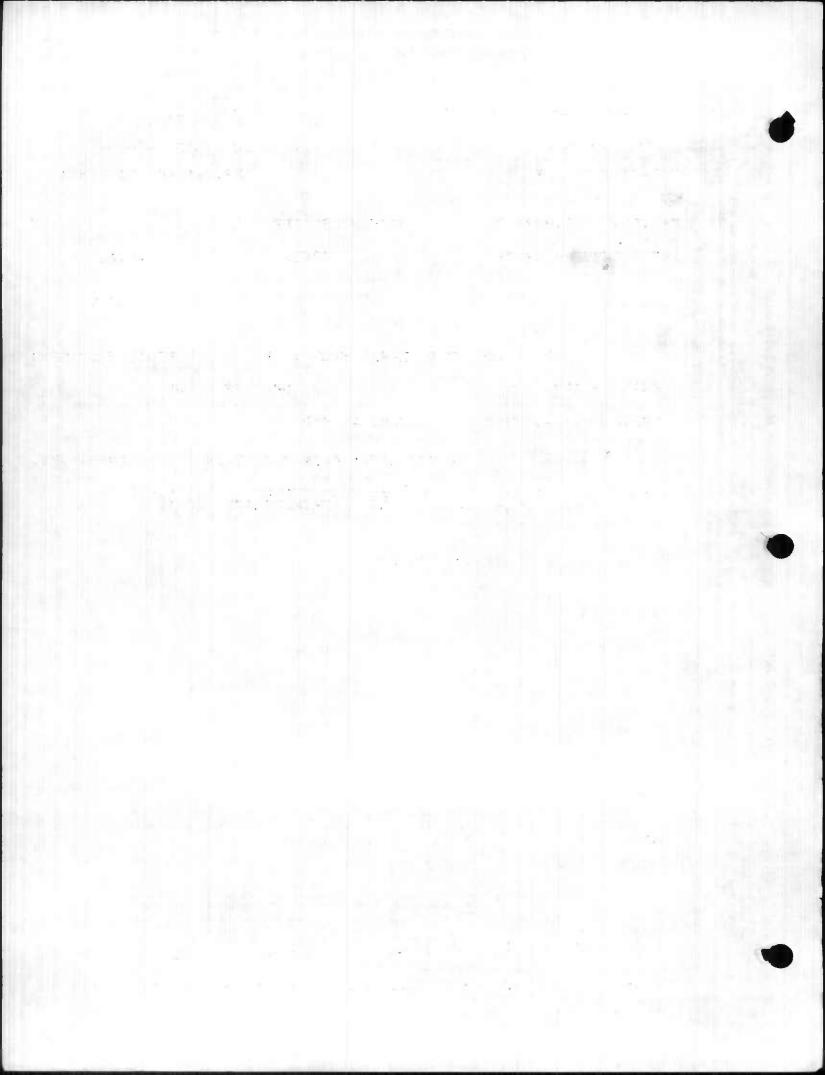
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KRISHAN MATHUR, MD., P.O. 1703, LA PLATA, MD BOX 20646 31. Dete filed (Month, Day, Year)

Registrar

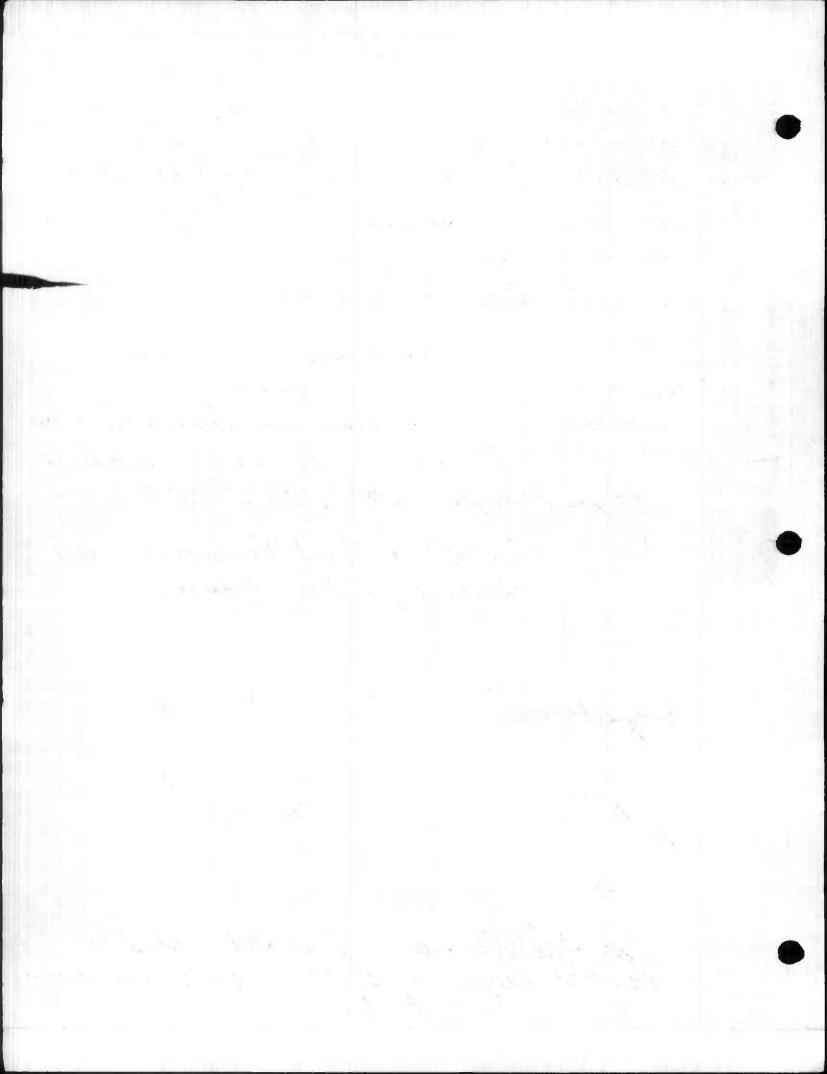
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State of Maryland / Department of Health and Mental Hygiene 99 24087

					,	Cert	ificate of	Death		Reg. No.	) (	4001
	Physici	an	Decedent's Neme (First, Middle, Last,	)					2. Dete of Dee	eth Dey	Year	3. Tima of Death
	/Medi		Lida Taylor Porter	·					July	14		9:20 PM
	Examir	er	4a. Fecility Neme (If not institution, give					4b. City, Town, or L	ocation of Deeth	4c. County	of Deeth	
			Shore Nursing & R					Denton		Carol		
d.	Funeral Director		5. Social Security Numbar  219-07-2085  Usual Residence of Decedent	7. Age	1 (In yrs. la 95	st birthday) Yrs.	Months Deys		8. Dete of Birth (Month, De) Sept 25	, Year) , 1903		pleca (Stata or Foreign ntry) yland
	nyland how		10a. Stete 10b. County	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10c. City,	Town or Loc	ation				1	I0d. Inside City Limits
	o Me	io.	Maryland Caroline		Hend	derson						1□ Yas 2√ No
	or 28	ire	10e. Street end Number				10f. Zip Code			10g. Citizen of	Whet Cou	ntry?
	th wi	a	16800 Henderson R	d Lot 88			2164	40		USA		
	ges 1 and 2 should be filed within 72 hours after deeth with the Meryland it of Health end Mentel Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinat must be notified at	Funeral Directo	11. Maritel Status  1 ☐ Never Married 2 ☐ Merried	12. Was Decedant E Armed Forces? 1 ☐ Yes 2 ☑ N		. 13. W	es Decedent of Yas, specify Cui	Hispenic Origin? (Sp ban, Mexican, Puerto	pecify Yas or No- Rican, etc.)	14. Red Bla	ca - Amari ck, White,	can Indien, etc.
21215-0020	as S.	þ	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Datas:		1	☐ Yes 2 ☑ No	Specify:		Specif	y: Wh	ite
Ď.	2 hor	bed	15. Decedent's Edu	cation		16e. Decede	nt's Usuei Occu	pation		16b. Kind of B		
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p	other other	BeC	17. Father's Neme (First, Middle, Last)					18. Mother's Nem	ne (First, Middle,	Meiden Sumer	na)	
Maryland	Mentel Merked of	TOE	Elijah Taylor					Louise	Kemp			
an	2 should end Men is marke aumatic		19e. Informent's Neme/Reletionship (Ty	rpe, Print)		19b. Meiling	Address (Stree	et end Number or Ru	rei Routa Numbe	r, City or Town	, Stata, Zij	Code)
	1 and 2 Health em 27 I		Helen Shewbrooks			16800	Henders	son Rd Lot	84 Hen	derson,	Mar	yland 21640
ore	of He item		20e. Method of Disposition		20b. Pte	ce of Dispos	ition (Neme of atory or other pl	eca)	Date	20c. Location	- City or To	own, Stete
Ĕ	Pages nent of I int: If ite		W Buriel 2 □ Cremetion 3 □ R 4 □ Donetion 5 □ Other (Specify)	emovel from Stete			ro Cemet		July19,1	999 Gr	eens	boro, MD
Baltimore,	permit. Pages Depertment of Important: If it any injury or o		21. Signature of Funerel Service License	90			Name end Addi					
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	Physician		snock, or neer reliure. List only or	ne ceuse on eech iin	е.		. 1		1		i	Onsat and Death
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	cuted	Examiner	Sequentially list conditions		Due to (or	es e consegu	ence of):					
o	an al	Щ.	Sequentially list conditions, if any, laeding to immediata cause. Enter Underlying Couse (Disease or Injury that initiated events					0			i	
68760,	death certificate be executed e attending physician and of for usa as the buriel-transit	edicai	Ceuse (Diseese or Injury thet initiated events rasulting in death) Lest	:	Dua to (or a	is a consequ	ance of):					
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	uires thet tha death cer signed by the attendir Id be detached for usa	Physician/N	Pert tt. Other significant conditions con	tributing to death bu	t not result	ing in the und	derlying cause g	iven in Pert I.	23b. Did t	obacco use co	ntribute t	o the causa of death?
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O	Attending or death.	tion	1 Deleturel 5 Pending Investigation	(Month, Dey	Year)	Injury	W	ork? □Yes 2□No	200. 2000.100 1	iow injury cocci		
Division	× = = =	Certification:	3 Suicide 6 Could not be determined	28e. Pieca of Inju building, etc.	ry - At hom . (Specify)	ne, farm, stree	et, factory, office	3	28f. Location (S City or Tow		ber or Run	al Route Number,
	To the Hospital c within 24 hours at To the Funeral D complataly filled in	edical	29a. Cartifier (Check only one) Certifying Phys	ner: On the basis of	exeminetio	edge, deeth on end/or inve	occurred et the testigation, in my	time, dete end plece opinion, deeth occu	, end due to the or	cause(s) end m	enner as s end due t	steted. o the ceuse(s)
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8			(14) 74	cuc	-m	0	0	3300	0/	///	97	/
			30. Neme and eddress of person who co	mpleted cause of de	eth (Item 2	23e) (Type, P	219 S	S. Wash	ngton &	st Ba	ston	7 mo 2160/
	Sta		31. Dete filed (Month, Dey, Year)	32 Registre	r's Signetu	re 4	loan	. ,			-	1



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $Q \ Q$ Certificate of Death 1. Decedent's Marte (First, Middle, Lest) 2. Date of Death 3. Time of Death Month 5 0700 City, Town, or Location of Death 4c. County of Death 4e Facility Name (If not institution, give street and number) If Under 1 If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Dev. 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (Stete or Foreign -Country). 1 M 2 F Months Days Hours Min 215-16-837 3 VIRGINAA 10 Usual Residence of Decedent 10d. Inside City Limits 10a Stele 10b. County 10c. City, Town or Location 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 75 nester 12. Was Decedent Ever in U,S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 131gc 1□ Yes 2⊠No Specify 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) DRIVER 01 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) M9/9/2 ober+5 Ses 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) NewYURK NY 10030 MoVence 150W 140 20 20c. Location - City or Town, State 20a. Method of Disposition 20b. Piece of Disposition (Neme of cemetery, cremetory or other piece Burial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) HCCOMAC 22. Name and Address of Facility Home FUNGRA 21. Signature of Funeral Service Licenses HARTON Accomor Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line? ZZITI Wharton UM 2330 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in death) Last Due to (or 23b. Did tobacco usa contribute to the cause of death? significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2□ No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to 24e. Wes an autopsy performed? completion of cause of death? 1 ☐ Yes 2 No 1 Tyes 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Yes 2 1 Inpatient 2 ER/Outpetient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural

**Physician** /Medical Examiner

be axec

Division of Vital Records, P.O. Box 68760

or Attending Physician:

Aftar

efter daath. Director: Aft

To the Hospital of within 24 hours e To the Funeral D

**Physician** 

/Medical

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7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner mant to rediffied at

permit. Pages 1 and 2 should be filed within 72 hours after death Department of Haalth and Mantal Hygiena. Important: If flem 27 is marked other than "natural", or flems 23 any Injury or other traumatic event, the Medical Examples managed.

Baltimore, Maryland 21215-0020

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sicien and burial-transit physicien the hes cartificata this

Examiner Physician/Medical þ Completed funarel director, Be Certification: To

5 Pending investigation 2 Accident

6 Could not be determined 3 Suicide 4 | Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Tes

2 □ No

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a, Certifier (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month), Day, Year)

se of death (Item 23a) (Type, Print) IMMS 5602

State Registra

Medical

31. Date filed (Month, Dey, Year)

JUL 21

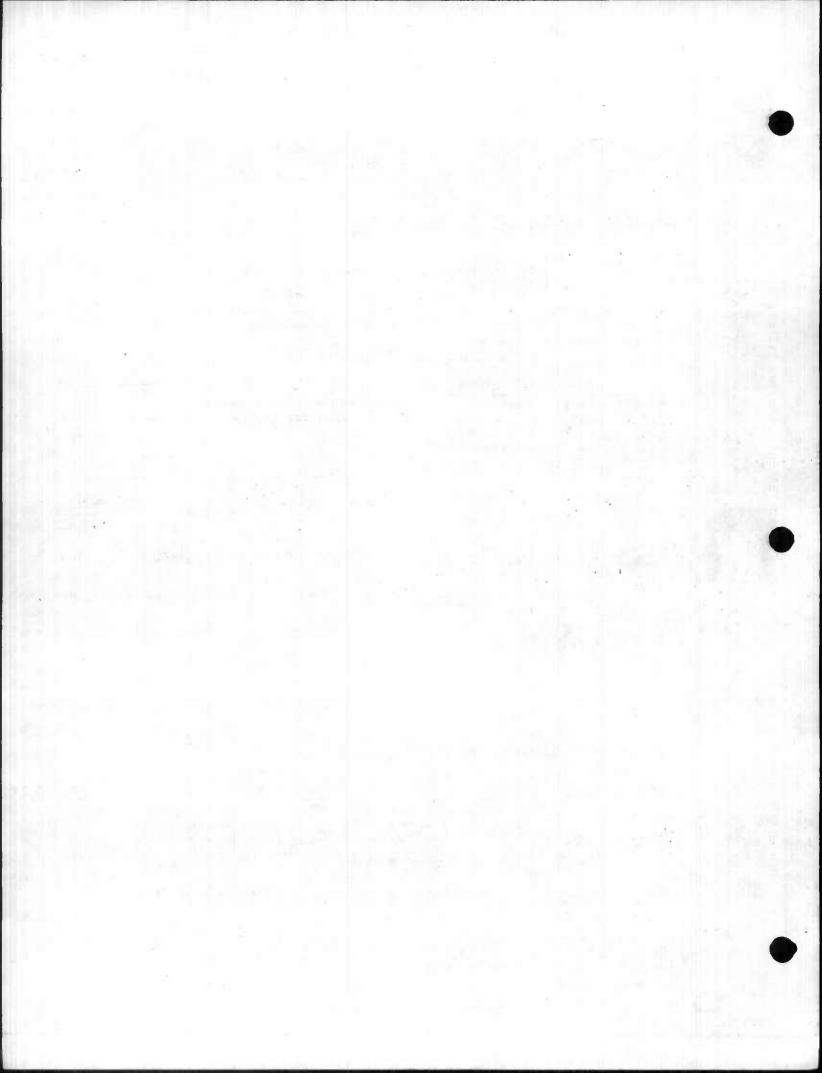
32. Registrar's Signature

Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner es stated.

State of Maryland / Department of Health and Mental Hygiene 9 24089

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	5. Social Securi	lemorial 1		ge (In yrs. last bir	thday) If Under		aston If Under 24 Hrs	8. Date of Birth	Tal		tate or Ecrain
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bed ls/	Pert II. Other sig	gnificant conditions of	ontributing to death t	out not resulting in	the underlying or	euse give	n in Pert I.	23b. Did t	obecco usa co	ntribute to the ca	use of death
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d by Jetac		70170								Tan	
signed by the attendir the detached for use by Physician/N		1 4									
een signed by hould be detac	deci	-bitus	vicers					24a. Wes	an autopsy med?	available	opsy findings prior to
as been signed by a should be detacl	deci	comyopo chitus	ulcers	•				24a. Wes period	an autopsy med?	available	
ate has been signed by page 2 should be detac Completed by Phy	deci	-bitis	vicers	•				24a. Wes perfor	med?	available	prior to
should should	25. Wes case re	ー り、 キッS		•			26. Place of De	perlo	med?	available completic of death?	prior to in of cause
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n 24 hours after death.  • Funeral Director: After this certific pletely filled in by the funeral director pletely filled in Certification: To Be	25. Wes case re axaminer?  1 Yes 2  27. Menner et D  1 Meturel  2 Accider  3 Suicide  4 Homicid  29e. Certifier (Check only one)  29b. Signeture at a constant of the constant	elerred to medical  Pel No  seath  5   Pending investigation 6   Could not be determined  1   Certifying Ph 2   Medical Examend   Medical	Hospitel: 1 Pripati 28a. Date of Inju (Month, De 28e. Piece of In building, e) 28e. Piece of In building, e)  ysician: To the best and menner st  completed cause of c M.D., 50	ent 2 ER/Ou  Jry Year) 28b. 1  jury - At home, fe tc. (Specify)  of my knowledge of examinetion and eled.  death (Item 23a)	rm, street, factory , deeth occurred d/or investigation,	Bc. Injury Work  To office  at the tim in my op  License	e, date and place inion, deeth occur	performance of the performance o	res 2 No  ne)  ence 6 Oth ow injury occur  street and Numb respect and place, 29d. Date signe	available completic of death?  1 □ Yes  Per (Specify)  red  per or Rural Route anner as stated, and due to the ca	prior to on of cause 2 No

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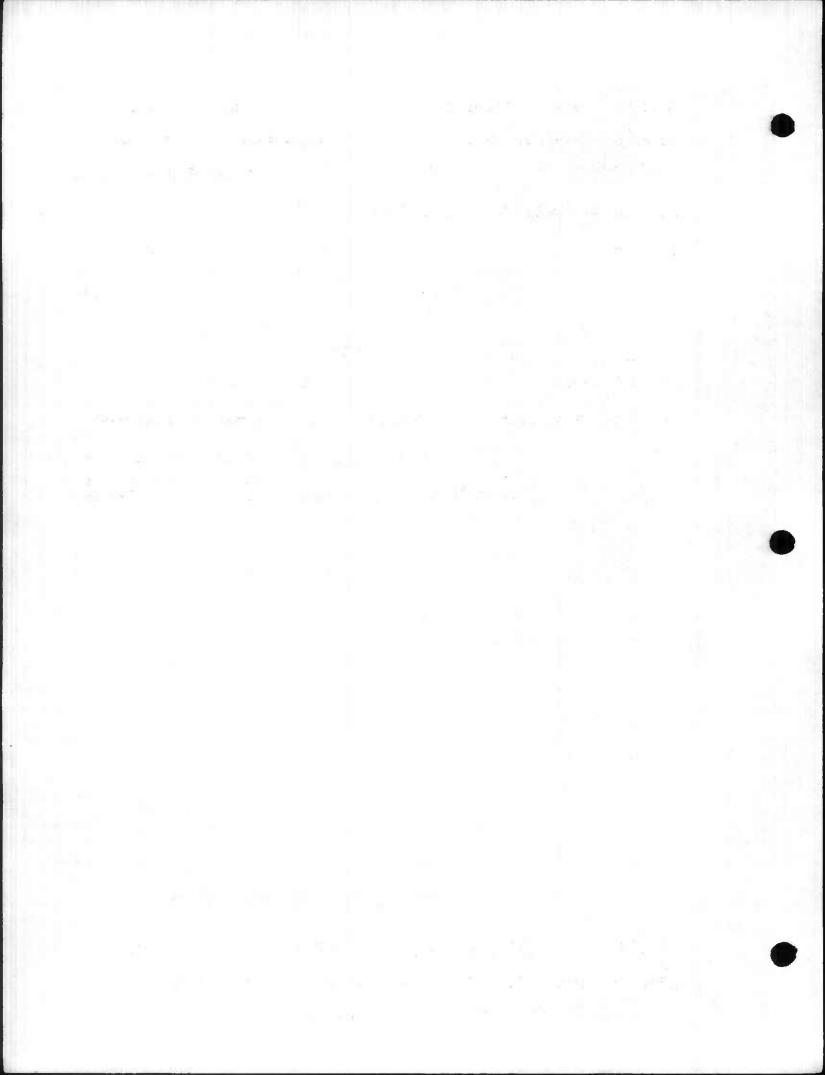
				State of I	viaiyiailu		rtificat			ariu k	iemai ny	giene 🖁 🖁 Reg. No.	2	40	90
	Division		Decedent's Neme (First, Middle, Last)								2. Dete of Death 3. Time of D				ne of Death
J	Physic /Medi		GEORGE LEE SIEBERT								July 13, 1999 4			:30 an	
	Exami										Location of Deeth 4c. County of Death				
			Washington County Hospital Hagers							_		ngton			
į	be filed within 72 hours after death with the Maryland call Hyglene.  Id other than "natural", or items 23a or 28a-f show a confied at a word, the Marilceal Examiner must be notified at a confied at a	Completed by Funeral Director	5. Sociel Security Number 6. S 219–36–3200	Sex 7 I⊠M 2□F	2□ F 7. Age (In yrs. lest birthday) If Under 1 Yeer Months Deys			Hours Min. (Mont			th by, Year) 25,1941		irthplace (State or Foreign Country) laryland		
Baltimore, Maryland 21215-0020			Usuei Residence of Decedent  10e. Stete 10b. County		10c. City, Town or Location							40d la			
			Maryland Washington Co. Hagerstown												
			106. Street and Number 13634 Tvy Way 217					2174				10g. Citizen of What Country? USA			
	r dea		11. Maritai Status	12. Wes Decede Armed Force	s?	13.	Wes Deced	dent of H	ispanic Ori	gin? (Sp	ecify Yes or No Rican, etc.)	- 14. Rec	ce - America	nerican Indian,	
	ours after		1 Never Married 2 Married 3 Widowed 4 Divorced	1 X Yes 2[ If Yes, Give Yeer or Dete	1 X Yes 2 Nonc /1E /EO			1 Yes 2 No Specify:			7 110411, 010.7		Table 4 bear		
	in 72 hours		15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usuei Occupation (Give kind of work done during most of wild be retired)  If a Do NOT use retired)							t of work	16b. Kind of Business/Industry				
	d within piene. r then	mple	Eiamentary/Secondery (0-12)	Coilege (1-4d	College (1-4or 5+)			oTuse retired) e Officer			City				
	il Hygiene. other ther	Be	12 17. Fether's Neme (First, Middle, Last,	4			TICE			r's Nom	. /First Middle	L			
	d 2 should th and Men 7 is marks traumatic		Arthur L. Sieber					18. Mother's Neme (First, Middle, Malden Surneme Treva Z. Eckert				110)	<i>a)</i>		
		2	19a. Informent's Neme/Rajationship /	19a. Informent's Neme/Raiationship (Type, Print) 19b. Mailir							ural Route Number, City or Town, Stata, Zip Code)				
			Faye Marie Siebe								stown, Maryland 21740				
	- 7 5 5		20a. Method of Disposition		com	e of Disp	osition (Nan	ne of		1	Dete	20c. Location			le
	permit. Pages Department of I Important: If Its any injury or or once.		1 XBuriei 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specif		emovel from Stete  Rest Haven Cemetery					1	Jun.16 Hagerstown, Maryland				vland
			21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd., N., Hagerstown, Maryland 21742												
			23a. Pert1. Enter the dispuse, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart latitudes. List only one cause on each line.												
d.	Physician /Medicai		shock, or neer lallyre. List only	ome ceuse on each	ina.										Between and Deeth
			immediate Causa (Finei disease or condition	e. Poorly Differential Adenocarcinoma Lung 6 months  Dua to (or as a consequence of):										onths	
П	Examiner		resulting in deeth)											iotreno	
Division of Vital Records, P.O. Box 68760,	pe is	Examine													
	and and il-tran	хап	Sequentially list conditions, if env. leading to immediate	Due to (or es e consequance of):											
	icate be executed physician and s the buriel-transit	al E	Sequantially list conditions, if eny, leading to immediata cause. Enter Underlying Cause (Disease or injury	C	5										
		edical	that initiated events resulting in death) Lest		Due to (or es e consequance of):								i		
	death certific e attending p od for use as	N.	d												
	d for	Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of de									on ad donth 3			
	the sche	hys	Tat it. Outer significant conditions contributing to death out not resulting in the underlying cause given in Pert 1.									Yee 2□No			
		by P									- 350			,	
	been s	Completed									24e. Wes	an autopsy ormed?	com	ieble p	psy findings rior to of cause
	The ate h	mo mo									10	Yes 2 No			2 No
		0	25. Wes case referred to medical	26. Pieca of Death (Check only ona)											
	5 00	To B	exeminar? 1 ☐ Yes 2 ☒ No	Hospital: Other:							Home 5 ☐ Residence 6 ☐ Other (Specify)				
	Attending Phir death. setor: After thi		27. Mannar of Deeth 1 ☑ Naturei 5 ☐ Pending	28a. Date of injury (Month, Dey Year) 28b. Tima c injury			of 2				28d. Dascribe how Injury occurred				
		catic	2 Accident invastigation				M 1 ☐ Yes 2			No					
Ξ	or Attendent efter deat Director:	Certification:	3 Suicide 6 Could not be determined	28a. Piace of Injury - At homa, farm, street, fectory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Routa Number, City or Town, State)					
	To the Hospital or Attending is within 24 hours effer death.  To the Funeral Director: Affer completely filled in by the funer		29a. Cartifiar  11 Certifying Physician: To the best of my knowledge, deeth occurred et tha tima, dete end plece, end due to the ceuse(s) and manner es steted.												
		edicai	29a. Cartifiar 1X Certifying Ph (Check only one) 2 ☐ Medical Exam	ysician: To the bes ninar: On the basis end menner	of examination	age, deet end/or in	n occurred e vestigetion,	et tha tim in my o	na, dete en pinion, daa	a plece, th occur	end due to the ed at the time,	ceuse(s) and ma dete end place,	anner es ste and due to t	ted. he cau	se(s)
	Vithin Fo the	Me	29b. Signeture and title of certifier	J. 010 d.		29c. License number				29d. Dete signed (i		d (Month, D	ey, Ye	ar)	
	->-0								062			July 14, 1999			
			30. Name end address of person who	completed cause of	f daath (item 23	a) (Type	Print)					July 14	, 177		
			dward W. Ditto,					ingto	on St	. н	agersto	wn, MD	21740	)	

DHMH 16 Rev 6/95

State Registrar

31. Dete filed (Month, Day, Year)

JUL 1 4 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 9 2 4 0 9

						Cei	rtificat	e of	Death			Reg. No.	_	4031
	Physic /Medi		1. Decedent's Nema (First, Middle, I Luella Mary SNYL				A				2. Dete of De Month July	Dey 199	9 Yeer	3. Time of Death 5:20 a.m.
	Exami		4a. Facility Nama (If not institution, g Colton Villa Nur						tb. City, Too Hage			th 4c. Count	y of <b>Dee</b> th shing	
	Funeral Director		187-16-4678	Sax 7. A 1 □ M 201 F	lga (In yrs. I 81	last birthday) Yrs.	If Under Months	1 Yaar Deys	If Undar Hours	24 Hrs. Min.	8. Data of Bi (Month, D	rth av. Year) 28, 1917	9. Birth	plece (State or Foreign ntry) ENNESSEE
	e Maryland 8a-f ahow	ctor	Usual Residence of Decedant  10a. Steta 10b. County  Maryland Was	shington	10c. City	, Town or Lo	agers	towr	2					10d. Inside City Limits  12 Yes 2 □ No
	th with th	Funeral Director	10e. Streat end Number 815 Georgia Aver	<i>ue</i>			10f. Zip	Code 2174	10			10g. Citizen of USA	Whet Cou	ntry?
020	72 hours after deeth with the Maryland nature!', or frems 23a or 28a-f ahow airel Examiner must be notified at	by	11. Maritel Stetus 1 □ Never Married 2 □ Married 3 Ѿ Widowed 4 □ Divorced	12. Wes Deceder Armed Forces 1 ☐ Yas 210 If Yas, Give Year or Detes	i? ] No				ispenic Orig an, Mexican Specify:	gin? (Sp , Puerto	ecify Yes or N Rican, etc.)	o- 14. Red Bie Specifi	ck, White,	can Indien, etc. hite
21215-0020	filed within 72 hours after Hyglene. ther then *nature!, or if ent, the Medical Experien	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12)	Education reda complated) Collega (1-40)	5+)		tant's Usue kind of wor DO NOT us OUSEK	rk done e ratire	during most d)	of work	ing	16b. Kind of B		ndustry
Maryland	o da bo	To Be C	17. Fether's Neme (First, Middle, Las Harsh Philpott	st)				-			e (First, Middle 2 Ann W	a, Maiden Surner 100 lsey	ne)	
	d 2 sh th end 7 is m traum		19e. Informent's Neme/Relationship Charles Snyder -				-					oer, City or Town		
Baltimore,	ages ant of t: If It				A .	leca of Dispo emetery, cran	-			17	Dete 7-14-99	20c. Location Hagers	-	
Balti	permit. Pa Departmen Important: any Injury once.		AD Burial 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify)  21. Signature of Funerel Sarvice Licensee  22. Nama and Address of Facility  415 E. Wilson Blvd., Hagerstown, Md.											
	Physiclan		23e. Pert1. Enter the diseesa, or co shock, or heert failure. List only	mplications thet cause y <i>on</i> e causa on eech	ad the deeth line.									Approximete Interval Between Onsat and Deeth
	/Medicai Examiner		Immediata Cause (Finel disaase or condition resulting In deeth)	. Altre		es o consequence		420	io vy	450	ULAR	DISIZA	103	Miws.
	cuted nd transit	Examiner	Sequentielly list conditions,	b. Insu				- Die	abete	o .				54eory.
68760,	rifficate be executed ng physician end s as the burial-transit	Medical Ex	Sequentielly list conditions, if any, leading to immediate causa. Enlar Undarrying Causa (Disaase or Injury thet initieted events resulting in deeth) Lest	c. CERT	BRO		LAR							2 years.
Box 6	death certific e ettending pl od for use as t			l d										
P.O.	thet the d	by Physician/	Pert II. Other significant conditions	contributing to death	but not resu	Iting in the ur	nderlying cr	ause giv	en in Pert f.			tobacco usa co Yes 2□ No		o the cause of death?
cords	been s	Completed b					a	ore				s an eutopsy ormed?	av	fare autopsy findings vallable prior to ompletion of causa deeth?
Vital Record	The ate h		25. Wes casa referred to medical								10	Yas 20 No		□Yas 2 No
>		To Be	examinar?	Hospital: 1 ☐ Inpat	ient 2 🗆 E	ER/Outpatien	t 3 DO	Δ Oth	ar _/		h (Check only	one) idenca 6 □Otr	or (Speci	6.0
ion of	를 를 들		27. Manner of Death  1 Naturel 5 Pending 2 Accidant Invastigation	28a. Dete of Inj (Month, D	ury	28b. Time of Injury		Bc. Injun Wor			-	how Injury occur		<i>y</i> /
Division	를 를 다	Certification:	3 Sulcida 6 Could not determined	289. Place of Ir	njury - At hor tc. (Spacify)	me, ferm, stre	eet, fectory	, office				(Street and Numi wn, Stata)	ber of Run	el Route Number,
	Me Hospital	edicai	29a. Certifiar 1 Certifying P (Check only one)	hysician: To the basis minar: On the basis end menners	of examineti-	viedga, daath on end/or inv	occurred e restigetion,	ot the tin	ne, date end pinlon, daat	d placa, h occurr	end due to tha ed et the time,	cause(s) end modele end pieca,	enner es s end dua t	teted. o the causa(s)

State Registrar 29b. Signeture end title of certifier

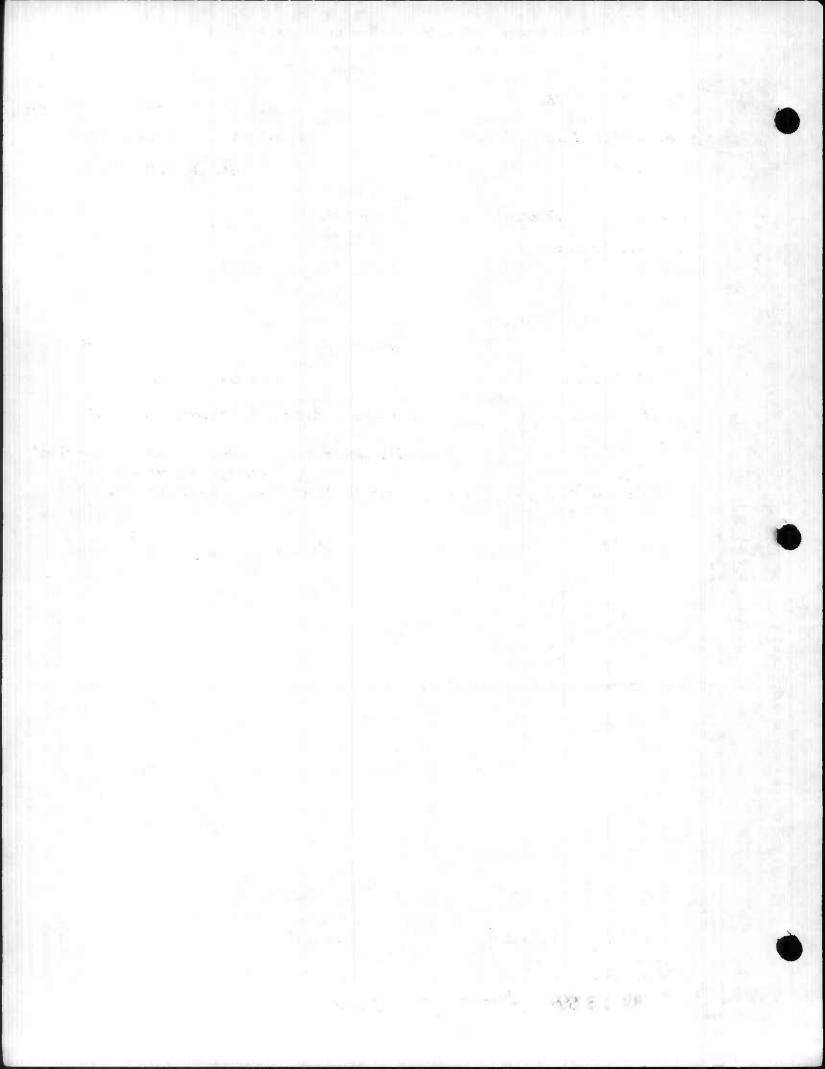
29c. Licansa number

D 28365

7-1299.

30. Nema end address of person who complated cause of deeth (Item 23e) (Type, Print)

MAN 2AR J SHAM 368 PMICC STRGET HAGERSTOWN MD 21740



State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Mary Louise SAUM 0:30 Am /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a\_Facility Name (If not institution, give street end number) **Examiner** Washington Hagerstown NURSING DFFMAN If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Days 1 □ M 2 F 218-62-8626 Yrs. 87 Director July 30, 1911 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show kam 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic event, the Medical Examiner must be notined at 1K Yes 2 □ No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 141 Elm Street 21740 USA 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 1 ☐ Yes 2X No If Yes, Give Yeer or Dates: 1 ☐ Never Merried 2 ☐ Married 1 Yes 2 No Specify: Specify: white þ 3₺ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If Itam 27 is marked other than "! Elementary/Secondary (0-12) College (1-4or 5+) homemaker her own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Keller Newton Morin Carrie Mort 2 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty L. Sama - daughter 13530 Paradise Dr., Hagerstown, Md. 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata permit. Pages I Department of H Important: If Ita any Injury or ot page. 1 Burlal 2 ☐ Cremation 3 ☐ Removel from Stete Rose Hill Cemetery 7-13-99 4 Donation 5 Other (Specify) Hagerstown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Maryland 21740 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Cardial unfaretion MONTH Immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner strending physician and for use as the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Physician/Medical Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? been signed by t should be detect 1 Yes 2 No 3 Probably 4 Unknown þ Completed 24a. Wes an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To this funeral 27. Manner of Deal 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury st Work? 28d. Describe how injury occurred After Hospital or Attending s after deau. 1 Antural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. within 24 hours of the total to the fune completely file 29e. Certifier 2 Medical Examiner: On the besis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ş 29b. Signeture and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AGERSTOWN, MS

Registrar

of Vital

Division

**DHMH 16 Rev 6/95** 

State

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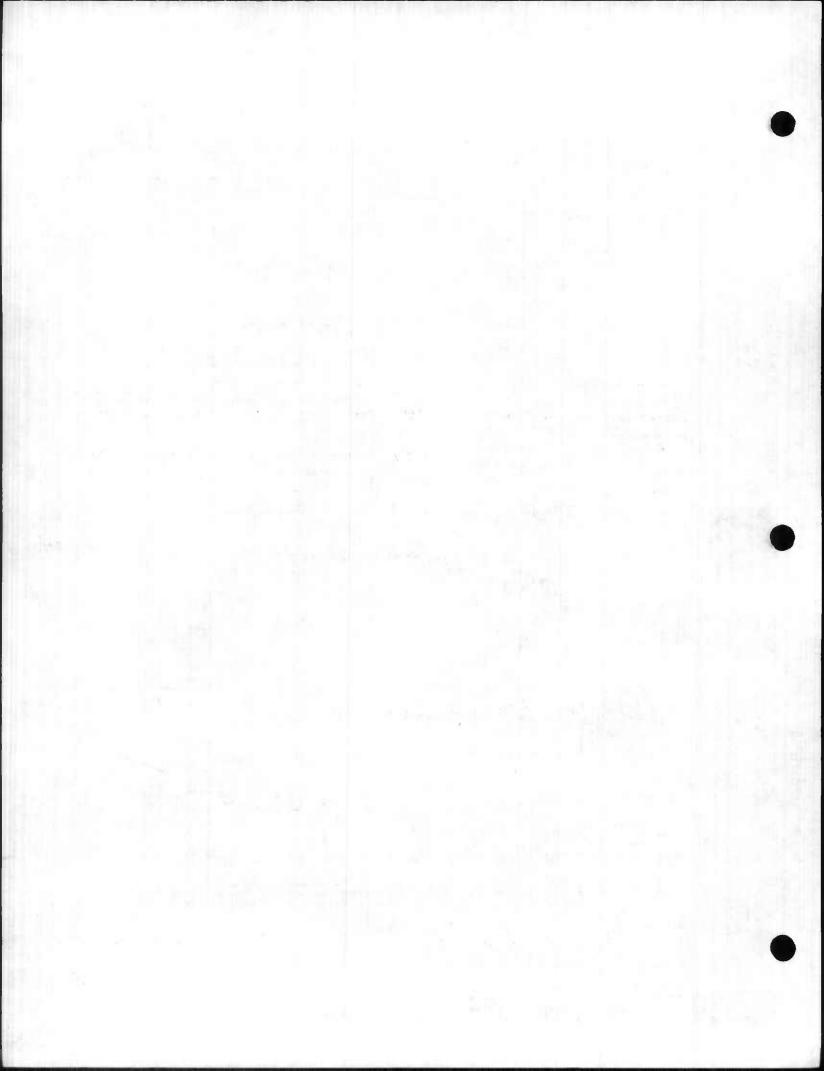
31. Date filed (Month, Day, Year)

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1 3 1999

1185

32. Registrer's Signature



State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 2. Data of Death 3. Time of Death 1. Decedant's Nama (First, Middla, Last) Month Physician Marilyn Alberta STSK )ul Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington | Months | Days | Hours | Min. | Min. | March | 23, 1927 | Vermont 5. Social Sacurity Number 7. Aga (In vrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** Months 1 M 25 F 72 Yrs. 009-12-5783 Director Usuel Residence of Daceden with the Maryland 10e State 10b. County 10c. City, Town or Location 10d. insida City Limits 1 Yas 2000 Maryland Washington Hagerstown ma 23a or 28a-f Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 12140 Hopewell Road 21740 Funeral death "naturel", or items 12. Was Dacedant Evar In U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, atc. filed within 72 hours efter 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 white 1 ☐ Yas 2 ☒ No Specify: Specify: þ 3 Nidowed 4 Divorced Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) the Medical 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) then Collega (1-4or 5+) Eiamantary/Secondary (0-12) 0-12 Hygiene. homemaker her own home 18 Mother's Name (First Middle Meiden Sumama) 17, Fathar's Nama (First, Middle, Last) Peges 1 and 2 should be a nent of Haalth and Mentel I mt: If item 27 is marked of unknown unknown 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 12140 Hopewell Road, Hagerstown, Maryland Mrs. Tina Rauth/daughter 20b. Place of Disposition (Nama of cematary, cramatory or other pleca) 20c. Location - City or Town, Stata 20a. Method of Disposition Data July 1999 10, 1 ☐ Burial 2 ☐ Crametion 3 ☐ Removal from Stata Hagerstown, Maryland Hagerstown Crematory 4 ☐ Donation 5 ☐ Othar (Specify) Minnich Funeral Home 22. Nama and Addrass of Facility 21. Signature of Fugerel Service Licensee 415 East Wilson Blvd., Hagerstown, Maryland 21740 Ussel 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death **Physician** Metastehe /Medical Immediata Causa (Finat ( gucer 11n Kum disaasa or condition rasulting in daath) Examiner Wilcon 20 year Examine Ohstructure physician and the burial-transit the death certificate be axecuted Sequentially list conditions, if any, teeding to immadiata cause. Entar Undarlying Ceusa (Diseese or Injury that initiated avants rasulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of): attanding pl for usa as 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown by 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy pege 2 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was casa rafarrad to medical Be 28. Pleca of Deeth (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 2 1 Inpatiant 2 ER/Outpatient 3 DOA this funaral 26e. Dete of Injury (Month, Day Year) Certification: 27. Manner of Daath 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred After 1 Neturel 5 Panding invastigation death. 1 Yes 2 No 2 Accident after deati 3 Suicida 6 Could not ba Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homlcide within 24 hours a To the Funeral D completaly filled 1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and dua to the causa(s) and manner as stated.
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated. 29a. Certifiar edical (Check only one) To the 29d. Data signed (Month, Day, Year) 29c. Licansa number 29b. Signatura and Itio gi MD 07, 10, 1999 30 Name and addrass of person who complated causa of death (Itam 23a) (Type, Print)
Dr Igbal 12821 Oak Hill Hagerstown Maryland Ighal

State Registrar 31. Data filad (Month, Day, Year)

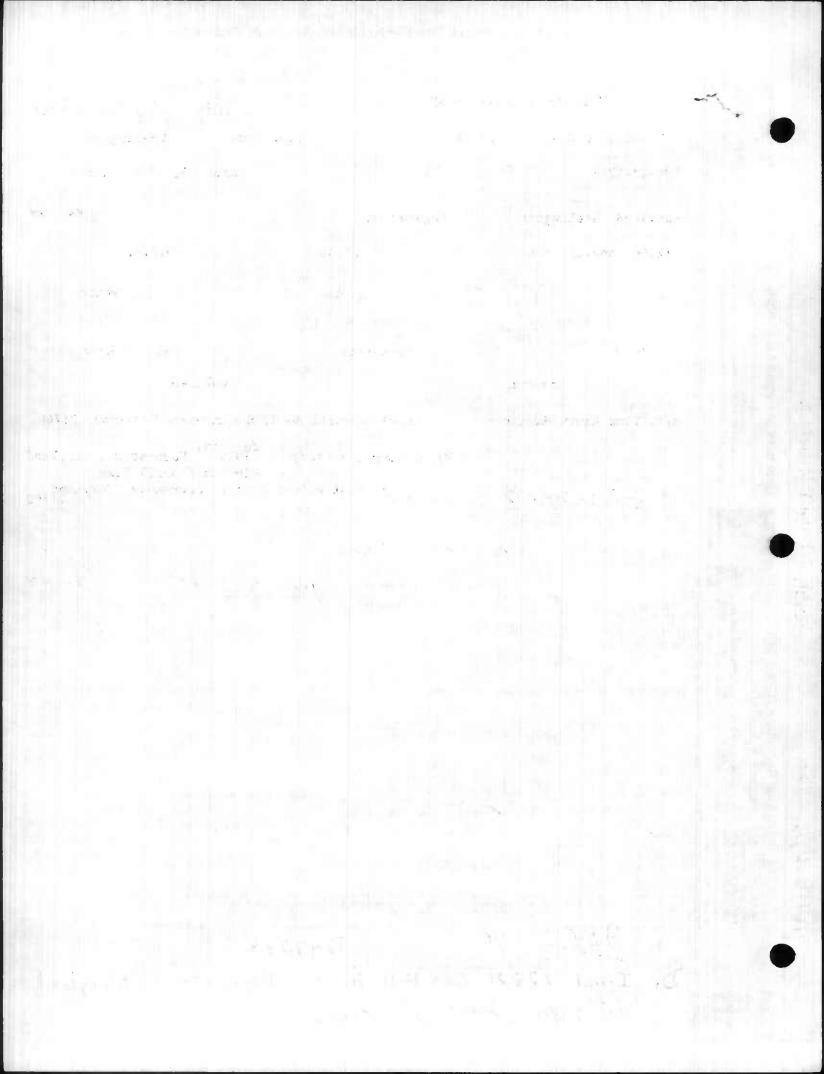
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32. Registrar's Signature

Sparls

Manlyn Alberta

MARILYN SISK



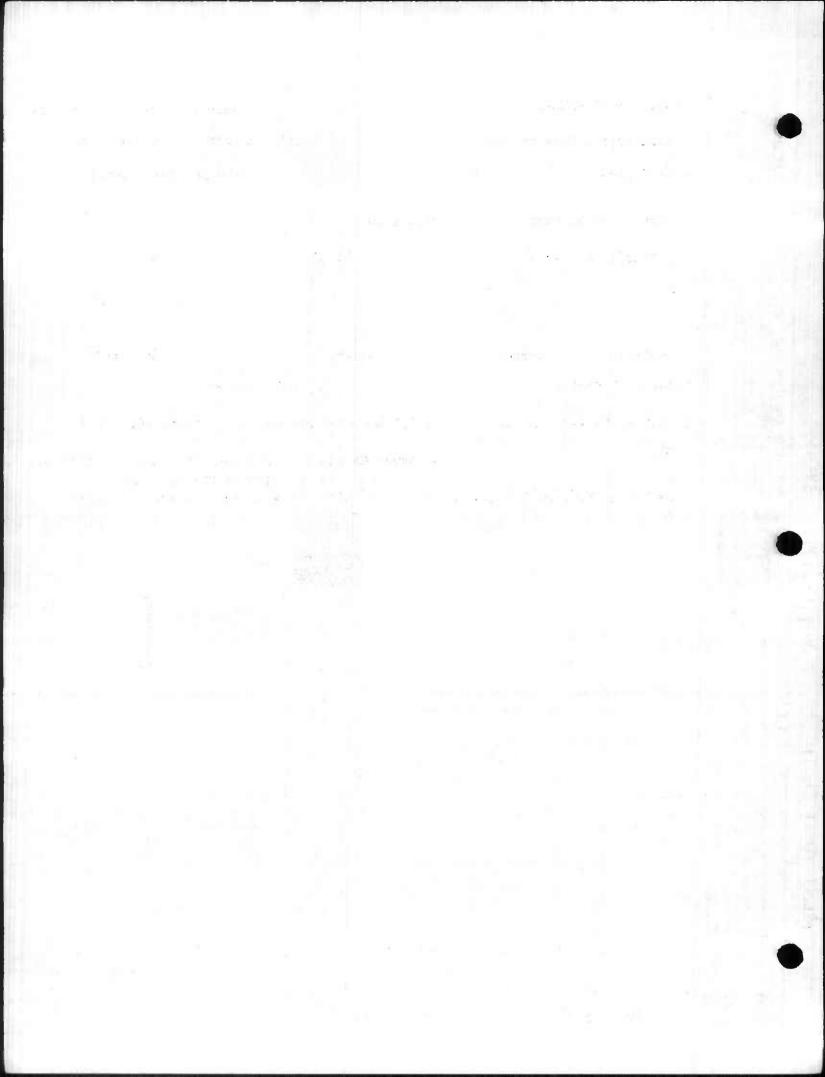
State of Maryland / Department of Health and Mental Hygiene

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	Page 2		Judith A. Seml	er - nie	ece	10	805	Roessn	er	Ave	nue,	Hager	stow	n, M	d. 2	1740	
5	of Healt of Healt litem 2		20a. Method of Disposition			20b. Plece o	Dispos	sition (Neme of	-10-0-			Date	20c. l	ocation -	City or To	wn, State	
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0	P P P P	Certification:	4 LI HOURCIGO		building, et	c. (Specify)						City or To	IWII, SIBI	6)			
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			30. Name and eddress of person Cunthia Kutto 31. Date filed (Month, Dey, Yea JUL 19	er Sar	10S N	D IIII	o N	redical	_ (	amp	45	RODA S	wk	130	M	acylo	and
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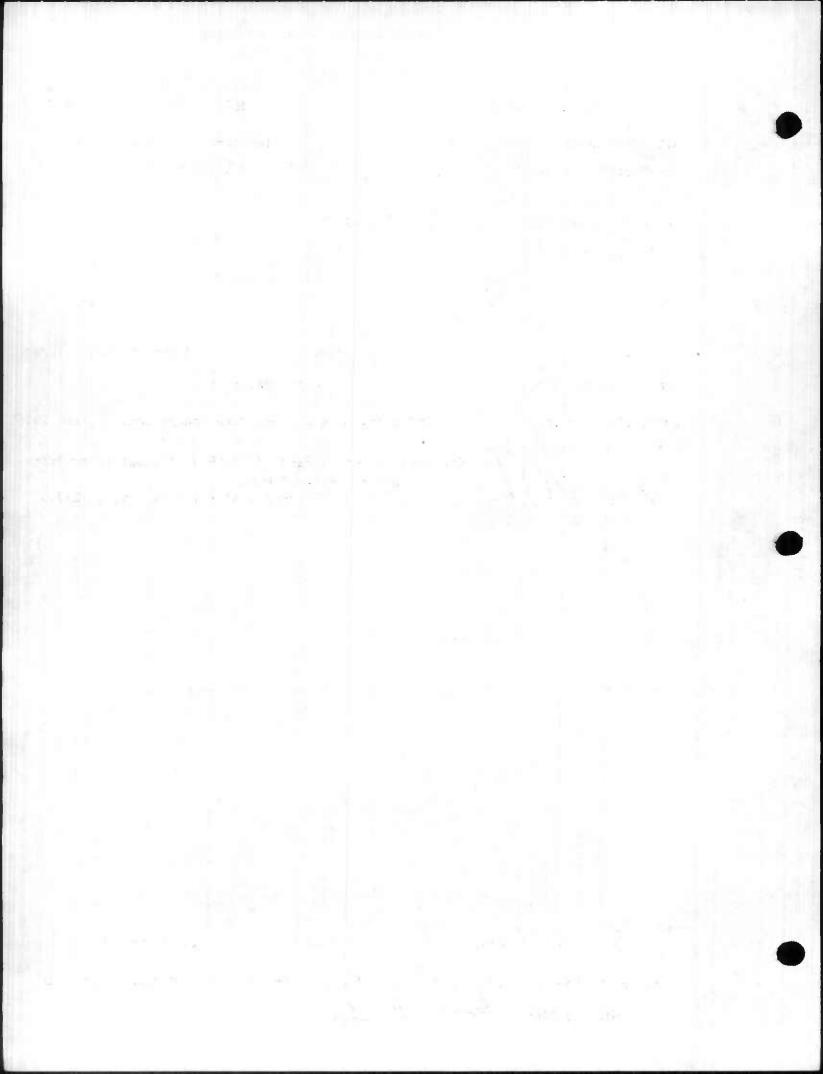
Robert Amel Shultz



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth **Physician** Pay July 1899 3:55PM Ruth Louise Shaffer /Medical 4a. Facility Neme (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8104 Neck Road Williamsport Washington Undar 24 Hrs. Hours Min. 5. Social Security Number If Under 1 Yaar 8. Date of Birth May 13, 1924 9. Birthplace (State or Foreign Mary land 6. Sex 7. Aga (In yrs. lest birthday) **Funeral** 1 M 2 F Months Deys Hours 75 219-12-0121 Yrs. Director Usual Residence of Decedant with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner nunt be notified at 1 Yes 2 No Director Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 6 8104 Neck Road 21795 items 23a USA by Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 (X)No if Yes, Giva Yeer or Datas: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Raca - American indian, Bieck, White, etc. filed within 72 hours efter 1 ☐ Never Married 2 ☐ Merried Baltimore, Maryland 21215-0020 6 1 Yes 2 No Specify: Specify: 3XXWidowed 4 □ Divorced White 'natural', Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Peges 1 end 2 should be filled within nent of Health end Mental Hygiene. int: If Item 27 is marked other then " Elementery/Secondery (0-12) College (1-4or 5+) 10 Clerical Aircraft Manufacturer 17. Fether's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Meidan Sumeme) Be Robert Welty Grace Jacob lula lizer 2 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Straet and Number or Rurel Routa Number, City or Town, Stete, Zip Code) permit. Pages 1 end 2 s Department of Health er Important: If Item 27 is any Injury or other trau once. Jerry Slonaker/Son 16780 Taylor's Landing Road Sharpsburg, Maryland 21782 20e. Method of Disposition
1 ☑ Burial 2 ☑ Cramation 3 ☑ Removal from State 20b. Plece of Disposition (Name of cemelery, cremetory or other place) 20c. Location - City or Town, Stete 4 ☐ Donetion 5 ☐ Other (Spacify) Greenlawn Memorial Park 7-20-99 Williamsport, Maryland 21. Signature of Fore ai Service Ucening 22. Nama and Address of Facility Home USBOTNE FUNETAL Home 1015 425 S. Conococheague St. Williamsport, MD 23e. Part1. Enter the disaese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiretory arrest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel Poorly Differentiated Bronchogenic Carcinoma diseese or condition rasulting in deeth) 6-8 months Examiner Dua to (or es e consaquence of) Examiner with metastasis The law requires that the death certificate be executed buriel-transit Sequentially list conditions, if eny, laading to immadiata cause. Enter Underlying Causa (Diseese or Injury that initieled events resulting in death) Lest pue Due to (or es e consequance of) P.O. Box 68760, ettending physician Physician/Medical Due to (or es e consequance of) use es the ed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? signed by the 1X Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by Completed 24e. Was an eutopsy performed? 24b. Ware eutopsy findings sysilabla prior to completion of causa of deeth? certificate hes 1 Yes 2 - No 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was casa raferred to medical 26. Piece of Deeth (Check only one) Othar: 4 Nursing Home 5 X X asidence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA After this 27. Manner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. injury et Work? Certification: 28d. Describe how Injury occurred 5 Pending Investigation 1 X Natural death. 1 ☐ Yes 2 ☐ No 2 Accident i Director: the 6 Could not be determined 3 ☐ Suicida 28e. Place of Injury - At homa, farm, street, fectory, office building, atc. (Specify) 28f. Location (Straat and Number or Rurel Route Number, City or Town, Stete) within 24 hours after To the Funeral Direct 4 \ Homicide Hospital 1X Certifying Physicien: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, data and place, end due to the cause(s) end menner stated. Medical (Check only the 29b. Signeture and title of certifier 29c. Licansa number 29d. Date signed (Month, Day, Year) July 19, 1999 HOR D01062 WK 30. Nema end eddress of person who completed causa of deeth (Item 23e) (Typa, Print) Edward W. Ditto, III M.D. 217 W. Washington St. Hagerstown, MD 31. Dete filed (Month, Dev. Yeer) 32. Regionar's Signeture State Spark JUL 1 9 1999 Registrar



State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent'a Neme (First, Middle, Last) Month **Physician** JERRY NMN SUK 1999 2212 09 U /Medical 4e Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Washington County Hospital Washington Co. Hagerstown If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Under 1 Year 5. Social Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthday) **Funeral** 15√M 2□ F Months Deys 90 April 21, 1909 Director 139-22-3204 New Jersey Usuel Residence of Decedent the Meryland 10a. Stete 10b. County 10c. City, Town or Location 10d. fnside City Limits r than "natural", or items 23s or 28s-f show the Medical Exercines must be notified at XXYes 2 No Directo Maryland Washington County Hagerstown 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? with 21742 USA 19816 Evelyn Avenue Funeral Peges 1 and 2 should be filed within 72 hours effer death nent of Health end Mental Hygiene. And 17 Is marked other then "natural", or Hema 23 and 18 filem 27 Is marked other then "natural", or Hema 23 Wes Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Raca - American Indien, 11. Maritel Stetus Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes XXNo Specify: Specify: White p 3 NWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) 8 0 Farmer Agricultural Farmer traumatic event, 17. Fethar's Name (First Middle Last) 18. Mother's Neme (First, Middle, Maiden Surname) Louis Suk Maria Klima 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. fnformant's Neme/Raletionship (Type, Print) other ! Emily Sodano, Daughter 19816 Evelyn Avenue, Hagerstown, Maryland 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury or permit. Pege Department important: if any injury or Sacred Heart Cemetery July 14 Vineland, New Jersey 22. Name end Address of Fecili 21. Signeture of Funeral Service Licensee Douglas A. Fiery Funeral Home felle immermen. 1331 Eastern Blvd. N., Hagerstown, Maryland 21742 23a. Part I. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** Sdewa /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner ailne buriel-transit and Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cousa (Disaesa or Injury that Initiated avants resulting in deeth) Lest Due to (or es a donsequenca of) hibret ve UWON physician s the buriel Physician/Medical Due to (or es e consequenca of): 88 980 Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Denknown been signed by should be detec þ 24b. Were autopsy findings eveileble prior to complation of cause of death? 24a. Wes an eutopsy Completed performed' page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate or Attanding Physician: director, 25. Wes case referred to medical Be 26. Piece of Deeth (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 2 ER/Outpatient 3 DOA this 28e. Dete of Injury (Month, Dey Year) funeral 28c. Injury et Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Division After 1 Weturel 5 Pending 1 ☐ Yes 24 hours after deeth. Funeral Director: Al Investigation 2 Accident 6 Could not be determined 3 Suicide Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 4 Homicide Hospital 1 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the ceuse(a) end mennar as atlated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end manner atlated. edical 29a. Cartifier (Check only one) within 2 To the ŝ 29d. Date aigned (Month, Day, Year) 29c. License number 29b. Signeture end the 0 47288 07 10 1999 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr Igbal 12821 Oak Hill Hu Hagerstown Oak Huenue

Registrar **DHMH 16 Rev 6/95** 

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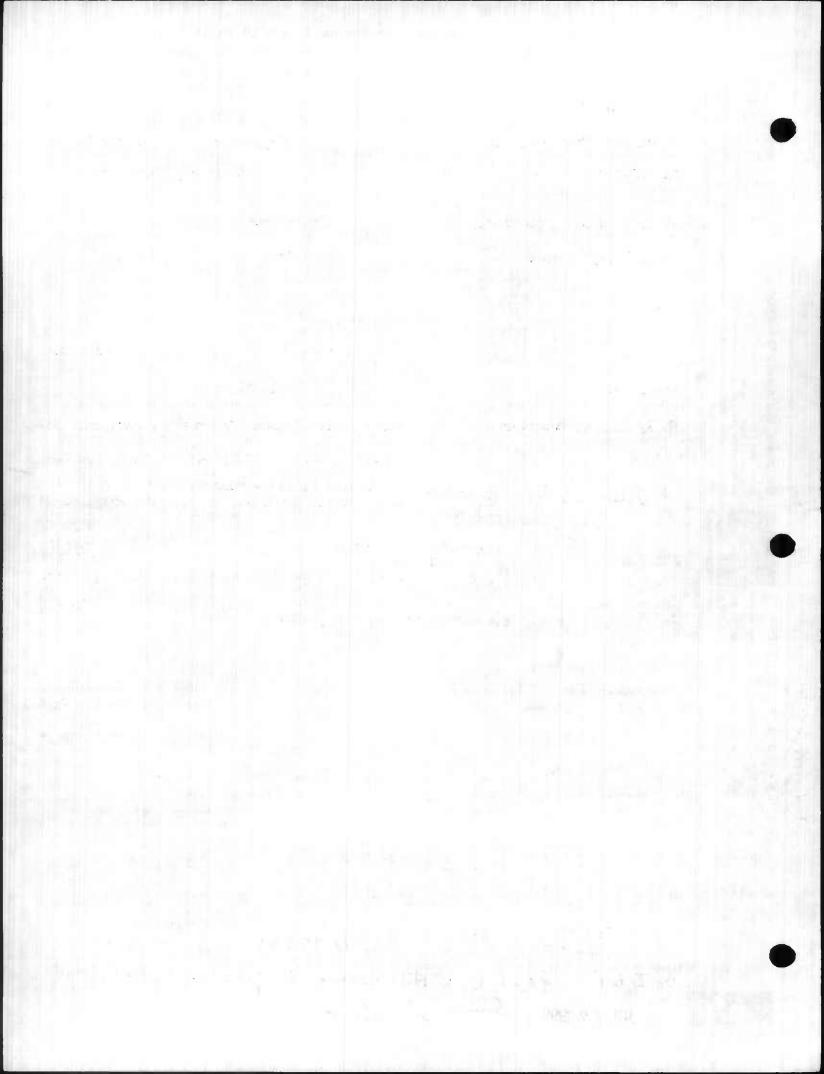
31. Dete filed (Month, Dey, Year)

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32 Registrer's Signature

Suk, Jerry NMN



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Data of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Emil Edwin Swanson July 13, 1999 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death 7628 Woodbine Rd. Woodbine 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours Min. 15 M 2 F 74 Yrs. June 16, 1925 Maryland 220-18-1480 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Carroll Woodbine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21797 United States 7628 Woodbine Rd. 12. Was Decedant Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, atc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ZYes 2 No 1945— If Yas, Give Year or Dates: 1947 1 Never Married 2 Married 1 ☐ Yes 20XNo White Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade complated) 16a. Decedent's Usual Occupation 16h. Kind of Business/Industry (Giva kind of work done during most of working life. DO NOT use retired)

Maryland State

20b. Place of Disposition (Name of cemetery, crematory or other place)

Ebenezer U.M. Cem.

22. Nama and Address of Facility

Funeral by Completed Elemantery/Secondary (0-12) 17. Father's Name (First, Middle, Last) Emil Swanson

6th

20a. Method of Disposition

19a. Informant's Name/Ralationship (Type, Print)

1 Burial 2 □ Cremation 3 □ Removal from State

Ruth Swanson - Wife

4 ☐ Donation 5 ☐ Othar (Specify)

Directo

10a State

permit. Pages 1 and 2 should be filed within 72 hours effer death with the Manyland Department of Health and Mental Hyglene. Intercent of Health and Mental Hyglene. Intercent: If term 27 is a marked other than "naturel", or items 236 or 28a-f show any injury or other treumatic avent, me Mangini Exp. Injust matilize notified at

**Physician** 

/Medical

Examiner

**Funeral** 

Director

**Physician** /Medical Examiner

physician end the buriel-trensit death certificate be executed 80 ettending p for use es ed by the deteched thet the Records. law requires certificate has b Division of Vital or Attending Physician: director, this funeral After ithin 24 hours efter death.

the Funeral Director: All

ompletely filled in by the fu efter death.

23a. Part1. Enter the disease, or complications that caused tha death. Do not enter the mode of dying, such as cerdiac or raspiratory arrest, shock, or haart failura. List only one cause on each lina. Immediate Cause (Final disease or condition resulting in death) Examiner Due to pr as a consequence of): Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that included the conditions of the conditions o stape Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of) 23b. Did tobacco use contributa to the causa of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ 24a. Was an autopsy performed? Completed Be 25. Was cese rafarrad to medical examiner? 26. Place of Death (Check only ona) Hospital: Lo

College (1-4or 5+)

1 Yes 210 No 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 PResidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. injury at Work? 1 Maturat 5 Pendino 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be datarmined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

2 Medical Examiner: On the besis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. (Check only one) 29b. Signature and titla of conflict 29c. License number 29d. Date signed (Month, Day, Year)

hau 30. Nama and addrass of person who domestad causa of death (Item 23a) (Type, Print)

westmuster HD21157

Highway Administration

21784

Approximate Interval Betwaan Onset and Death

6 mo

24b. Were autopsy findings available prior to

completion of cause of death?

Means

20c. Location - City or Town, State

July 16, 1999 Winfield, MD

18. Mother's Name (First, Middle, Maiden Sumama)

Mamie Conaway

7628 Woodbine Rd. Woodbine, MD 21797

Burrier-Queen Fuenral Home

19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, Stata, Zip Code)

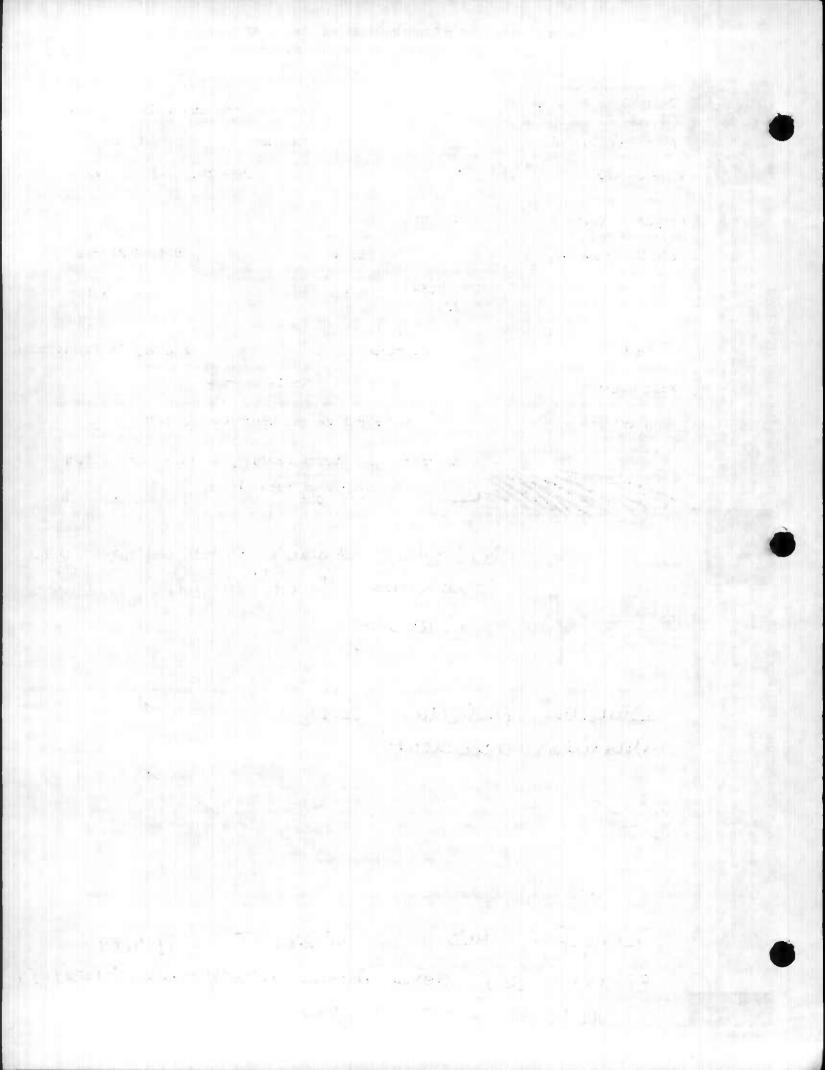
1212 West Old Liberty Rd. Winfield, MD

Acre Hone FRE151 295

31. Date fited (Month, Day, Year) 32. Registrar's Signature

Certification:

within 2



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death **Physician** Bernice Leona TRUMPOWER JULY /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) **Examiner** Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. last birthdey) **Funeral** Months 1 □ M 257 F Yrs. 219-12-1770 84 Director July 26, 1914 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location "natural", or items 23s or 28s-f show Maryland Directo Washington Hagerstown 10e. Street and Number 10f. Zip Code 11 W. Baltimore Street 21740 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decadent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: by 3 Widowed 4 ☐ Divorced

College (1-4or 5+)

unknown

Specify: white 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry

20

unknown 17. Father's Name (First, Middle, Last) Ottmer Berry Smith

19e. Informant's Name/Relationship (Type, Print)

Elementary/Secondary (0-12)

Gertie Lee Overstreet 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)

factory worker

Maxwell J. Miller - son 13720 Lois St., Hagerstown, Md. 21740 20a. Method of Disposition 20b. Piace of Disposition (Name of cemetery, cremetory or other place) 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 21. Signature of Funerel Service Licensee

15. Decedent's Education (Specify only highest grede completed)

20c. Location - City or Town, State 7-22-99 Hagerstown, Maryland

22. Name and Address of Facility

Premmia

Due to (or es a consequence of):

MINNICH FUNERAL HOME

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

415 E. Wilson Blvd., Hagerstown, Md. 21740 Approximate

18. Mother's Name (First, Middle, Meiden Sumeme)

Physician /Medical Examiner attending physician end for use as the bunal-transit

certificate be executed

been signed by the

**Director:** After this certificate has d in by the funeral director, page 2

filled in by after

within 24 hours a To the Funeral C completely filled

or Attending

death

page

Rumpowek, Bernial

Vital Records, P.O.

Examiner

Physician/Medical

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Completed

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Certification:

Completed

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Hygiene.

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permit. Pages 1 Department of Hi Important: If iten any Injury or ott once.

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury resulting in death) Last

Immediate Cause (Finel disease or condition resulting in death)

Arterio Due to (or as a consequence of):

Consentin Heart Faither Due to (or as a consequence of):

relevation Cardinarale

Onset and Death

2 wms

3. Time of Death

0545

10d. Inside City Limits

1 ¥Yes 2 □ No

Birthplace (State or Foreign Country)

Virginia

1999

Washington

14. Race - American Indien Bleck, White, etc.

leather company

4c. County of Death

10g. Citizen of What Country?

USA

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

centro basance

-phenologicales Denian

24e. Was en eutopsy performed'

24b. Were autopsy findings evailable prior to completion of cause of death?

26. Place of Death (Check only one)

1 Yes 2 No

25. Wes case referred to medical 1 Yes 2 No

1 SNatural

3 ☐ Suicide

29a, Certifier (Check only

2 Accident

4 Homicide

27. Menner of Deeth 5 Pending Investigation

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28c. Injury at Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28d. Describe how injury occurred

1 Yes 2 AND

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 1 Ctrifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as atated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

23b. Did tobacco usa contributa to the cause of death?

1 Yes 2 No 3 Probably 4 3 4 known

-con pros

P)08) Q

JULY 20, (999

30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print

Detta 31. Date filed (Month, Day, Year) JUL 2 2 1999

32 Registrer's Signature

Hagerstown and 21740

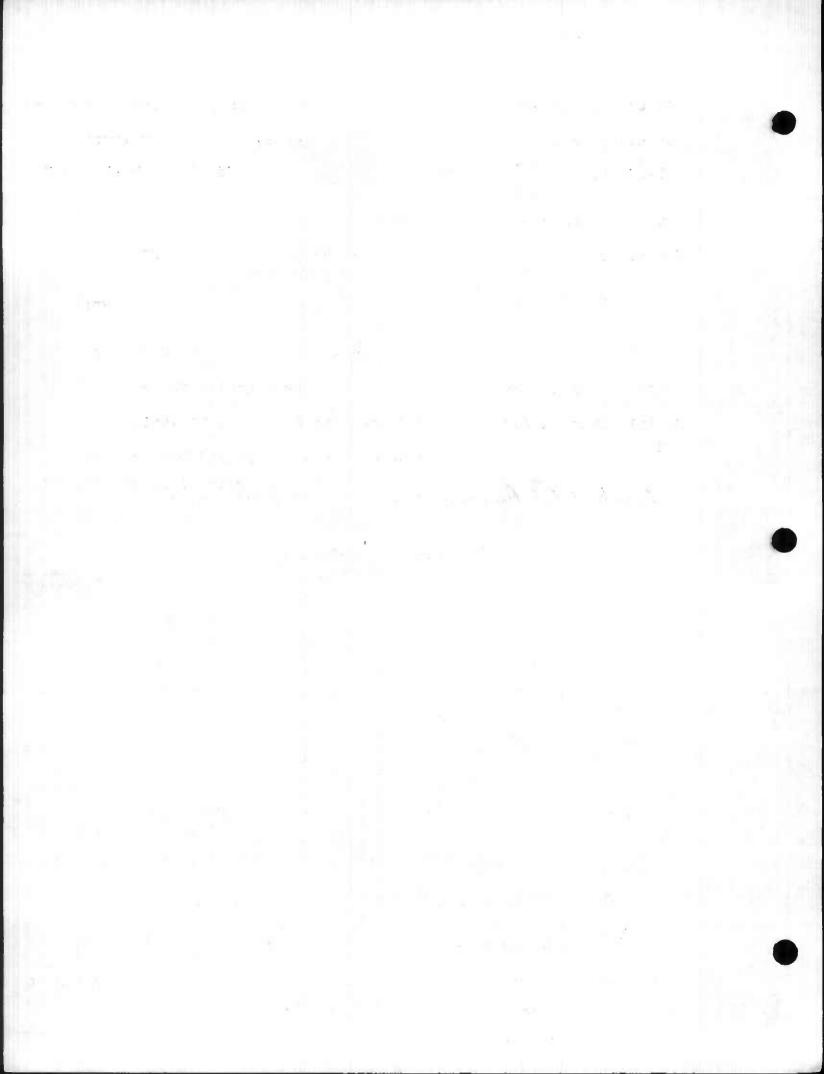
State Registrar

manager and special endings. CANAL STREET, 

				State of Ma	ryland / I	Department of Certificate	of Health and I		ene 9 9	24	099	
		ш	1. Decedent's Name (First, Middle, Les	it)				2. Dete of Deeth	•	3.	Time of Death	
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5	Exami	ner	4a. Fecility Neme (If not institution, give	street and number)			4b. City, Town, or L	Town, or Location of Deeth 4c. County of Death				
L			704 Alamo Lane		d t t	thday) If Under 1	Lusby Year If Under 24 Hrs.					
	Funeral Director		5. Social Security Number 6. Security Number 11 Sec	ox □ M 2XIXE 7. Age	(In yrs. last bii 62		Peys Hours Min.	8. Dete of Birth (Month, Dey, 4/5/37	Year)	9. Birthplace Country) Vash.,	(State or Foreign	
	Maryland a-f show	tor	10a. Stete 10b. County  MD Calve		10c. City, Tow	n or Location					nside City Limits	
	th the	Director	10a. Street end Number			10f. Zip Co	ode	10	g. Citizen of W	hat Country?		
	th wil		704 Alamo Lane			20	657		USA	1		
50	d within 72 hours after death with the Maryland jiena. I than "natural", or flems 23a or 28a-f show the Modical Exacitner must be notified at	y Funeral	11. Meritei Stetus  1 Never Merried 2 Merried	12. Wes Decedent E Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give			t of Hispanic Origin? (S) Cuben, Mexicen, Puerto No Specify:	pecify Yes or No- p Rican, etc.)		- American ir , White, etc.	ndlan,	
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	€ £ € £	Be Co	17. Fether's Neme (First, Middle, Last)			CIGI		ne (First, Middle, M			,	
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Maryland	2 should and Men is marks	-	19a. Informent's Neme/Reletionship (T		195	. Meiling Address (S	treet and Number or Ru			Stete, Zip Cod	le)	
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ore	of Ha		20e. Method of Disposition 1 X Burlel 2 ☐ Cremetion 3 ☐	Domestal from Chata	20b. Plece o cemete	f Disposition (Name ry, cremetory or othe	of r plece)	Dete 2	0c. Location - 0	City or Town,	Stete	
altimore,	Page: nent of ant: If i		4 □ Donetion 5 □ Other (Specify			morial G		/22/99	Dunkir	ck, MI	)	
Balt	permit. Pages 1 an Department of Haai Important: If Item 2 any injury or other 2003.		21. Signeture of Funerel Service Licens	J Keen	mrs		ox 121, D	aymond			ne, PA	
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		Examiner	resulting in deedily	b. ————	ue to (or es a	consequence of):	d			8	monthy	
	and and II-tran	xan	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	D	ue to (or es e	consequence of):						
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687	ficate phys	-	thet initieted events resulting in death) Last	D	ue to (or es e	consequence of):				į		
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s, P.O.	requiras that the death certifical seen signed by the attanding phy hould be detached for usa as th	by Physician/Med				Tallo dilidollyilig dodd	o growth art of the	1×(Y•		3 Probably		
Division of Vital Records,	≥ 00 00 ×	Completed						24e. Was an perform		avellabi	utopsy findings le prior to tion of cause h?	
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Ita		Be	25. Wes cese referred to medicel examiner?				26. Place of Dee	th (Check only one	)		$\wedge$	
2	Physician: r this certific and director,	To	1 Yes 2 No	Hospitel: 1   Inpatien	2 ER/Ou	tpatient 3□ DOA	Other: 4 Nursing H	ome 5 Residen	ice 6 DOthe	(Specify)		
ב	ding PI h. After th funera		27. Menner of Death 1 Netural 5 ☐ Pending	28e. Dete of injury (Month, Dey		Time of 28c.	Injury et Work?	28d. Describe how	v injury occurre	d		
sio	death.	cati	2 Accident Investigation 3 Sulcide 8 Could not be			M	1 Yes 2 No					
Divi	itei or Ati urs after d rai Direct ited in by	Certification:	4 Homicide determined	28e. Plece of Injur building, etc.	y - At home, fe (Specify)	rm, street, fectory, o	fice	28f. Location (Stre City or Town,	eet end Numbe Stete)	r or Rural Rou	ite Number,	
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific complately filled in by the funeral director.	fedical	(Check only one) 2 Medical Exami	elcian: To the best of iner: On the basis of e end menner stets	xaminetion en	d/or Investigetion, In	he time, date end plece, my opinion, deeth occur	end due to the cau rred et the time, det	use(s) and man te end plece, at	nar as stated nd due to the	cause(s)	
	With To t	2	29b. Signeture and title of certifier	owant	-	29c. L	27 189	29	d. Dete signed	(Month, Dey,	Year)	
_			30. Neme and address of person who	ompleted cause of dec	) oth (item 23e)	(Type, Print)			1 1	1 (		
8			Zahir Yousas	im.D.	2415	1 Solomo	ns Island	Rd. Hu	intingto	M.nw	\$ 300 B	

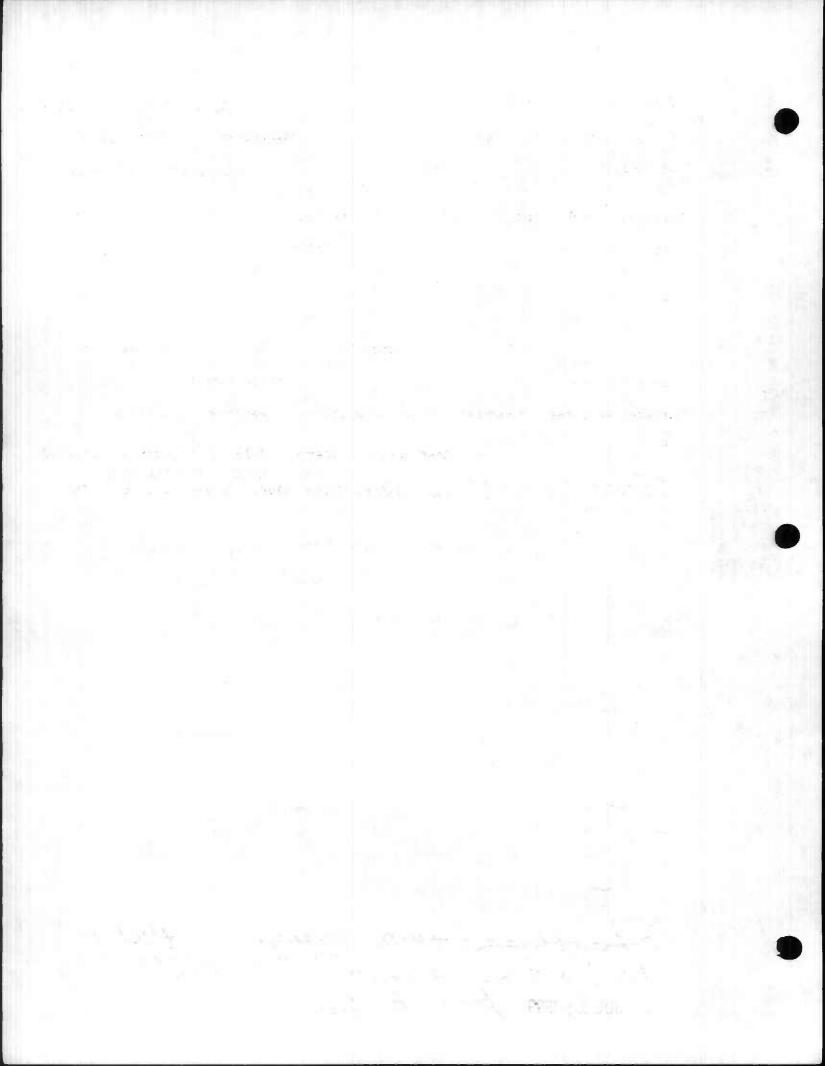
DHMH 16 Rev 6/95

Registrar



State of Maryland / Department of Health and Mental Hygiene 0.0

				Certificate of		Reg	g. No.	24100
п	Dhuala		Decedent's Name (First, Middle, Last)			2. Date of Death Month	Dev Year	3. Time of Deeth
J	Physic /Medi		Julia Meta WILLIAMSON				, 1999	6:25 a.m.
	Exami		4a. Facility Name (If not institution, give street and number)	10.	4b. City, Town, or Lo	cation of Death	4c. County of Dea	ath
			Colton Villa Nursing Home		Hagers	town	Washin	gton
	<sub>c</sub> Funeral Director		103	hday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) Feb. 1, 18	(ear) 9. Bit C	rthplace (State or Foreign ountry) rginia
	pug *		Usuel Residence of Decedent           10a. Stete         10b. County         10c. City, Town	or Location				40d balds Ob I lake
	Aaryl aho	5						10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	the A	Director	Maryland Washington  10e. Street and Number	Hagerst 10f. Zip Code	OWII	40	0111	
	ath with	ral Dir	805 Dale Street	2	1740		g. Citizen of What C	ountry?
21215-0020	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or ferma 23a or 28a-f show ord, the Medical Examinet must be notified at	d by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever In U,S.  Armed Forces?  1 □ ∀es 2 ☒ No  If Yas, Giva  Yeer or Dates:	13. Was Decedent of H If Yes, specify Cubs		ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi Specify: W	
5-0	72 h natu	Completed	15. Decedent'a Education 16a. ( Specify only highest grade complated)	Decedant's Usual Occup	oatlon during most of worki	na 16	6b. Kind of Business	/Industry
121	d within piene. r than	ig.	Elementary/Secondary (0-12) Collega (1-4or 5+)	(Give kind of work done life. DO NOT use ratired	d)			
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nd	should be filed and Mentel Hygi marked other imatic event, it	Be	17. Father's Name (First, Middle, Last)		18. Mother's Name			
7	should be and Mentel Ind Mentel I	L	James Templon			e Mummer		
Maryland	0 0 0 2			Mailing Address (Street				
	s 1 and 2 if Health itam 27 I			05 Dale Str	eet, Hage	rstown,	Md. 21/40	
Baltimore,	0 0		1X Burial 2 ☐ Cremation 3 ☐ Removel from State cametery	Disposition (Name of c, crematory or other plea Haven Cemet			oc. Location - Cify or agerstown	Town, State , Maryland
Balt	permit. Pege Department Important: If any Injury or		21. Signature of Euperal Service Licensee	22. Name and Addre	ss of Fecility MI		NERAL HOM	
	-		Part1. Enter the disease, or complications that caused the deeth. Do no shock, or heart failura. List only one cause on each line.					Approximate
	Physician /Medical Examiner	ner	Immediate Causa (Final disease or condition resulting in death)  a.   Due to (or as a condition or as		rie Cu	g de	seese dis.	Interval Between Onset and Death
ox 68760,	n certificate be executed anding physician and use es the burial-transit	n/Medical Examiner	Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a condition of the cond	venel	iasuff	were	1	
Bo.	for for	Cla	Part II. Other significant conditions contributing to death but not resulting in t		and Death	Ant Didash	4.10	
P.0	the ach	y Physician/	Demente	ne underlying ceuse giv	en in Part I.			to the cause of death?
Vital Records,	a law requires that has been signed to ge 2 should be det	Completed by				24a. Was an performe	d?	Were eutopsy findinga available prior to completion of cause of daath?
<u></u>	t as a	ပ္ပို				1 □ Yes	2 440	1□ Yes 2☑No
/ite	ysician: Tha i is certificata he director, page	Be	25. Was case referred to madical examiner?		26. Placa of Death	(Check only ona)		
of	Physician: this certific ral director,	2	1 ☐ Yas 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp		4 LUNIUSING HOP	ne 5 🗆 Residan	ce 6 Other (Spe	ocify)
Ē	Attending Ph ar deeth. ector: After thi by the funeral	Certification:	27. Manner of Death 28a. Data of Injury 28b. Tir 1 ■ Natural 5 □ Pending (Month, Day Year) Injury		y at k?	8d. Describe how	injury occurred	
Division	or Attending letter death. Director: After in by the fune	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	M 1 🗆	Yes 2 □ No			
Ξ	or Att efter d Direct J in by	E	4 Homicide datermined 28e. Placa of Injury - At homa, farm building, etc. (Specify)	1, street, factory, office	2	28f. Location (Stre- City or Town, :	et and Number or Ri State)	ural Route Number,
0	irs of rai D							
	To the Hospital or within 24 hours efter To the Funeral Dir completely filled in	edical	29a. Certifier (Check only one)  1 ☐ Certifying Physician: To the best of my knowledga, one)  1 ☐ Medical Examiner: On the basis of examination end/one end manner stated.	daath occurred at the tim or investigation, in my or	na, data and placa, a pinion, death occurre	nd dua to the caused at the time, date	se(s) and menner as and place, end due	s stated. e to the cause(s)
	To the within 2 To the comple	ž	29b. Signature and taje of certifier	29c. License	e number	290	. Date signed (Mont	th, Day, Year)
			1 butter 1 a	1.D. DO	04131	- One	7/16/	49
		1	30. Name and address of pursurn who completed cause of death (Item 23a) (T	ype, Print)	PAN 1	- Cors	BIRC	th.D
			(33 & min St. Has	serstown	, unt	21	740	1112.
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1	1			
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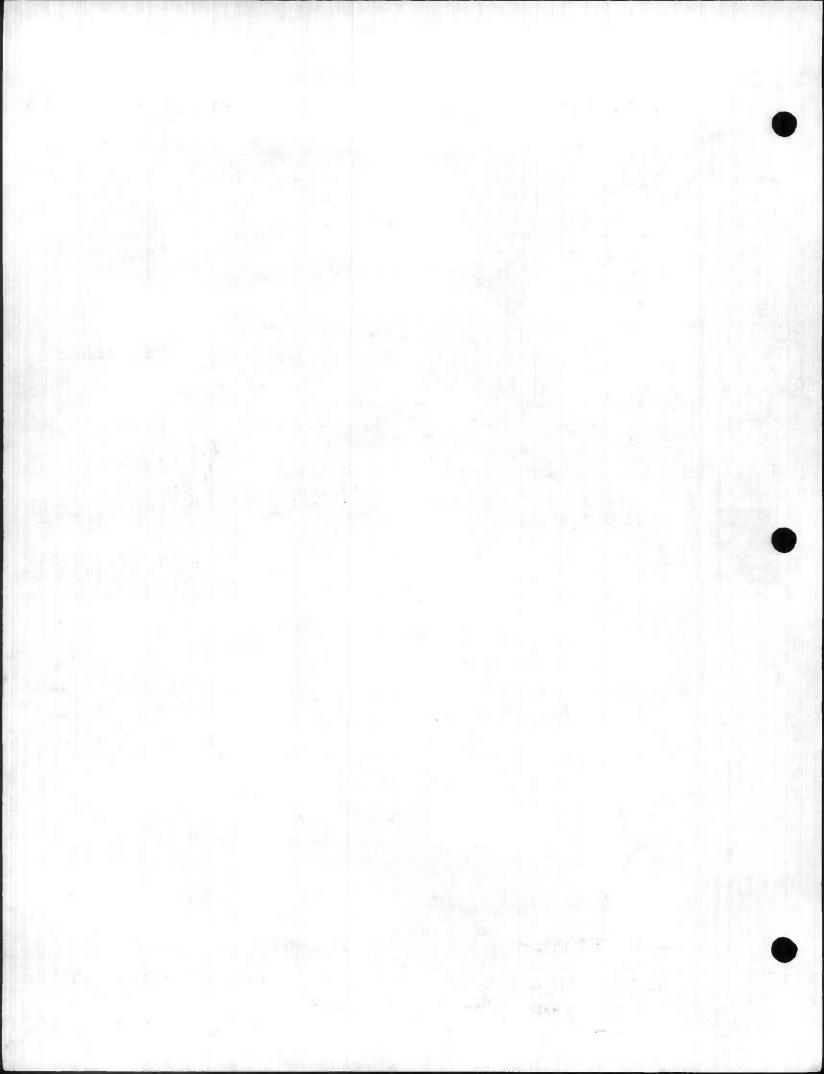


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State of Maryland / Department of Health and  Certificate of Death	Mental Hygiene	99	24	11	7
Certificate of Death	Reg. No.			,	
	2. Date of Death		3. Ti	ma of	Dea

					C	ertifica	te of	Death		Reg. No.	-	4101
Di di	1. Decedent's Na	me (First, Middle	, Last)						2. Date of I Month	Death Day	Year	3. Tima of Death
Physician /Medical	H. A. H. I. A. M.	C. WOLF	ES						July			4:30 PI
Examiner		(If not institution,	, give street and nu	mber)				4b. City, Town,	or Location of De		ty of Deat	
	REEDER '	S NURSI	NG HOME					BOONESBO	ORO.	WASH	INCTO	N
Funeral	5. Social Security		6. Sex	7. Age (In yrs	. last birthda		r 1 Year	If Under 24 H	rs. 8. Date of I	Birth		hplace (State or Foreign puntry)
Director	232-54-	-3440	1□M 200F	88	Yrs.	Months	Days	Hours M	DEC. 1	2, 1910	Co	WV
9	Usual Residence	-										
death with the Maryland ms 23s or 28s-f show f.msi be notified at neral Director	10a. State	10b. County		10c. C	ity, Town or	Location						10d. Inside City Limits
28a-f aho noutred at	WV	BERK	ELEY		MART:	INSBUR	l.G					10 Yas 2 No
or 28e-f a	10e. Street and N	umber				10f. Zi	p Code			10g. Citizen o	What Co	untry?
23a d	220	O N. SPR	ING STRE	ET		2	25401				USA	
office must	11. Marital Status			edent Ever in U	U,S. 13	3. Was Dece	dent of h	lispanic Origin?	(Specify Yes or I	No- 14. R	ce - Ame	rican Indian,
		rried 2 Marrie	ed 1 Yes	2 No				an, Mexican, Pu	eno Hican, etc.)		eck, White	9, 9tC.
۵		4 Divorced	If Yes, G Yeer or I	ve Dates:		1 Tes	2KJ No	Specify:		Spec	ily: WH	ITE
event, the Medical	10	15. Decedent			16a. Dec	edent's Usu	al Occup	ation	- 41	16b. Kind of	Business/	Industry
Medical Exa	Elementary/Sec		t grade completed) College (		life	DO NOT	onk done ise retire	during most of v d)	rorking			
# E	12	oridary (0-12)	3	1-401 347	1	WATCH	MAKE	R		WOL	FES .	JEWELRY
F O	17. Father's Name	(First, Middle, L	ast)		,				ame (First, Midd	lle, Maiden Sum		72112
To B	GTLRERT	RUSSEL	L LITTEN					FRANCE	2 MTN	NICK		
THE P	19a. Informant's !				19b. Ma	ilina Addres	s (Street			nber, City or Tow	n. Stete. Z	Zio Code)
other traumatic event, the B			ALL/DAUGH	TEP	7.3					OWN, MD		
other ti	20a. Method of Di		ALL/ DAUGI	20b.	Place of Dis	position (Na	me of		Date	20c. Location		
-	1X Burial 2	Cremetion	3 Removal from	State	cemetery, cr	emetory or	other ple					
5		5 Other (Sp		GR	EEN HI				7/9/99	MARTINS	BURG	, WV
eny injury o	21. Signature of F	uneral Service L	Licensee	1				ss of Fecility	MT 207	II WING	O.M.	
• α	Che	res	M. L	How.	w	PO	BOX	821. MA	ME 327 RTINSBUR	W. KING	ST.	
	23a. Part1. Enter	the disease, or o	complications that	eused the dea	th. Do not e							Approximata Interval Between
ician			,								1	Onset and Death
dical	Immediate Cause disease or conditi	(Final		Dunge	mon	10					- 1	2 10000
ner	resulting in death		8		or as a cons						1	2 whs
je je				Acia	ns at	A-					1	11. 1.
bunar-transit	Sequentially list of	onditione	b	Due to (	or as a cons	A IV.						quis
Ex	Sequentially list of if any, leading to cause. Enter Und	mmediate		*		ره مس						
20	Cause (Disease of that initiated even	r injury ts	c	Due to (	or as a cons	U.G.						YRS
Medical Examiner	resulting in death	Last			20/06							
for use a			d	21	MA						-	YRS.
- 40	Part II Other elen	Minant condition	ns contributing to d	eath hut not read	aultina in the	unded des		on in Dect t	22h D	id tabanaa uua a	on tells etc	to the cause of death?
be detected to by Physic	Part II. Other sign					underlying	cause giv	en in Fait t.		- 1 md		robebly 4 Unknow
be det		<i>F</i>	throsc	lerosi	5.				_   ''	Yes 2VNo	3[[	TOOLDIY 4 ONKHOW
Q Q									24a W	as an autopsy	24b.	Ware autopsy findings
Completed										rformed?		available prior to completion of cause
0 0												of death?
director, page To Be Corr									1[	Yes No		1 ☐ Yes 2 ☐ No
D Ctor	25. Was case refe examiner?	erred to medicat						26. Place of D	eath (Check onl	y one)		
		No	Hospital:	Inpatient 2	ER/Outpati	ient 3 D	OA Oth	ner: Nursing	Home 5 ☐ Re	sidence 8 🗆 C	ther (Spe	cify)
neral	27. Manner of Det	th 5 ☐ Pending	28a. Date	of Injury th, Day Year)	28b. Time Injury	of	28c. Injut Wor	y at	28d. Describ	e how injury occ	urred	
atic	2 Accident	investiga	ation			М		Yes 2 □ No				
E DY	3 ☐ Suicide 4 ☐ Homicide	6 Could ne	ned 208. Pieci	of Injury - At h	nome, farm,	street, facto	ry, office			(Street and Nur Town, State)	nber or Ru	ural Route Number,
Certification:			Julia	ing, etc. (opeci	""				ony or .	own, olato,		
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	29e. Certifier	1 X Certifying	Physician: To the	best of my kn	owledge, dea	ath occurred	at the tir	ne, date and pla	ce, and due to th	ne cause(s) and	manner as	stated.
pletely fill	(Check only one)	2 ☐ Medical E	caminer: On the b	asis of examination of the state of the stat	ation and/or	investigation	n, in my o	pinion, death oc	curred at the tim	e, date end place	, and due	to the cause(s)
completely filled in by the funeral	29b. Signature eq	d title of certifier				29	c. Licens	se nu <i>m</i> ber		29d. Date sign	ned (Mont	h, Day, Year)
1.7		Stry	1				24	4996		Fully	8	1999
	20 Name and ad-	rose of name	the complete de	o of death the	m 92a) (T	a Print	/ 1	1112		0-7	,	
	Ju. Name and add	Cox Man	nho completed caused ik 20311	Lannas	m zda) (Typi - Doad	B OO!	acho	co Mam	land 21	713 (301	) 43	2-3470
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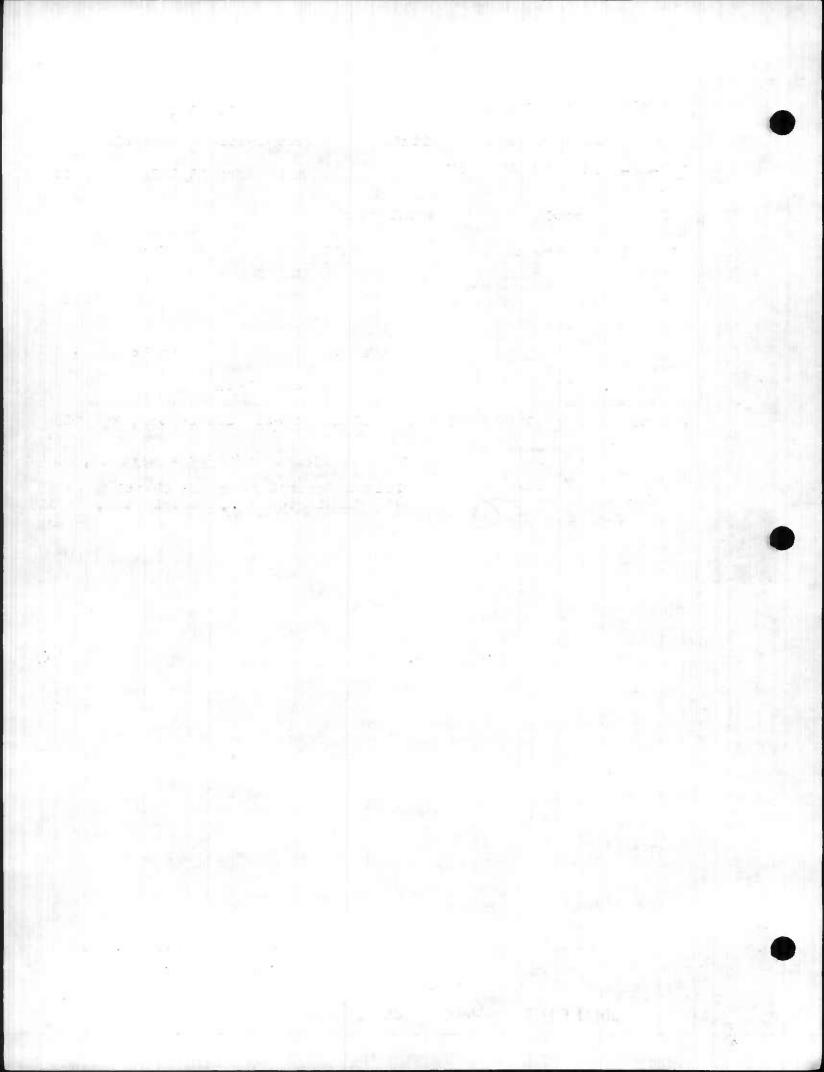
DHMH 16 Rev 6/95

Name:



State of Maryland / Department of Health and Mental Hygiene 99 21, 102

					ertificat		Death		Reg. No.	241	UZ
	Physician	Decedent's Nama (First, Middle,	Last)					2. Date of Dea Month	ath Day	Vear	o of Death
	/Medical	Adeline Mary						July	14, 199		:50
	Examiner					1	lb. City, Town, or I	Location of Death	4c. County	of Death	
7		Carroll County			4	1 Voor	Westmin		Carr		
	Funeral Director	324-09-5486		(In yrs. last birthdi 87 Yrs	Months		Hours Min.	8. Date of Birl (Month, Da May 3		9. Birthplace (Sta Country)	Sconsin
	pue A.	Usuel Residence of Decedent  10a. Stete 10b. County		10c. City, Town or	Location					10d. Inside	City Limits
	Maryler 4 ahow	MD Carro	11	Westm	inste	r					es 2 No
	the partition	10e. Street and Number			10f. Zip	Code			10g. Citizen of W	/hat Country?	
	for death with the Mai r flores 23s or 28s-fa for must be notified	108 Willis St				211			USA		
21215-0020	F	3 ☑ Widowed 4 ☐ Divorced	12. Wes Decedent Examed Forces?  1 ☐ Yes 2 ☐ No My Yes, Give Year or Dates:	ver in U.S.	If Yes, spec		ispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	Specify:	White	
O In	2 ho	15. Decedent's	Education	16a. De	cedent's Usu	al Occup	ation	4 in a	16b. Kind of Bu	siness/Industry	
2	ould be filed within 72 hou Mental Hygiene.  Erked other than "nature matic event, the Medical Tro Re Commissed of the Medical Tro Re Commissed of the Medical Residu	(Specify only highest s Elementary/Secondery (0-12)	College (1-4or 5+	) (G	e. DO NOT u	se retired	during most of wor f)	King			
7	la para la la la la la la la la la la la la la		3		memak	er			Own Ho		
Maryland	d oth	17. Father's Neme (First, Middle, La					18. Mother's Nen		Meiden Sumam	9)	
<u>X</u>		Ernest L. Dahl					Rose F				
Jar	ts C	19a. tnformant's Neme/Reletionship					and Number or Ru				
	permit. Pages 1 and Department of Health Important: If Item 27 eny Injury or other to once.	Kristin Vander	rvalk/daug	hter 14			Street				
0	Pages 1 nent of H int: If Ne iry or ot	20e. Method of Disposition  1 Buriel 2 Tremation 3	☐Removel from Stete		crematory or o		(8)	Date	20c. Location -	City or Town, State	
	permit. Pag Department Important: If eny Injury o	4 □ Donetion 5 □ Other (Spe		Carrol				7/15/9	9 Hamps	stead, 1	/ID
Bai	permit. Departrimonta Importa eny Inja	21. Signature of Funeral Service Lo			22. Name an	- Til -	7	Jome er	d Chan	0.7	
	40 = e a	1. CC			412 W	ashi	ington 1	Rd. We	stmins	ter. MD	21157
		23a. Parti. Enter the disease, or co shock, or heart failure. List on	mplications that caused to	he death. Do not	enter the mod	le of dyin	g, such es cardiac	or respiratory a	rest,	Approxi Interval	21157 nata Between
) I	Physician									Onset a	nd Death
	/Medical Examiner	Immediate Cause (Final disaase or condition resulting in death)	. Metast	-at-,c	Duari	an	Can co	er		1 m	men
			. Metast Gastro	ue to (or as a con	sequence of):					ι ο /	
	nsit n		U			L	sleed			0 0	S
	icate be executed physician and s the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Ama	m 7 C	sequence of):					2 0	lays
68760,	siciar buni	Cause (Disease or injury	C							100	2/3
	E 0 0 =			ua to (or as a cons Umoni						50	loxs
O B	at the death cert d by the attending etached for use Physician/M		0								1
	the a the a hed f	Pert II. Other significant conditions	contributing to death but	not resulting in the	e underlying o	ause giv	en in Part t.	23b. Did 1	obacco use con	tribute to the cau	se of death?
, P.	es that the death certific igned by the attending p be detached for use as by Physician/Mex							10	Yes 2□ No	3 Probably	Unknown
Division of Vital Records, P.O. Box	requir							24a. Was perlo	an autopsy med?	24b. Were autop available pr completion of death?	or to
2	e has							101	es 2 No	1 🗆 Yes	a∏ No
E .		25. Wes case referred to medical					26 Place of Dec			10163	20140
>	hysician: his certific il director To Be	exeminer?	Hospitel:	2 ER/Outpa	tient 3 DC	Oth	er: 4 Nursing H	lome 5 Resid	0 100	v (Spaciful	
o uc	be or Attending Physicien: all after death. all Director: After this certification by the funeral director, Certification: To Be (		28a. Dete of Injury (Month, Day	28b. Time	e of 2	28c. Injur Wor	y at k?		now injury occurr		
<u>s</u>	death tor:	2 Accident investiget 3 Suicide 6 Could not	be	. At hanna 41-	M		Yes 2 □ No	20f Leasting //	Stand and Aliente	er or Rural Route N	lumbor.
$\geq$	or A	4 ☐ Homicide determine	28e. Place of Injur- building, etc.	(Specify)	street, tector	y, OMICE		City or Tox		er or riural rioute r	rumoer,
_	C filled a	29e. Certifier 1 Certifying I	Shunialan, To the heat of	mu limanda da di da		at the sin	and data and also				
	in 24 hours he Funera pletely fill edical	(Check only 2 Medicat Ex	Physician: To the best of aminer: On the basis of a and menner state	xaminetion and/or	r investigation	, in my o	pinion, deeth occu	rred et the time,	date end place, a	nner as stated. and due to the caus	se(s)
	To the Hospital or I within 24 hours after To the Funeral Dire completely filled in b Medical Certi	29b. Signature and title of certifier	tan		290	. Licens	e number		29d. Date signed	(Month, Day, Yes	1)
	- 5 - 0	Din Kin	_ m.p.		0	57.	(00		July	14 190	9
		30. Name and address of narron wh	o completed cause of de-	th (ttem 23a) (Tur	ne Print) /	cal	17 7 AA A	1.1 1	man 11 a	17/11/	0 1
		Jul 16	00 menur:	al Aven	40 . 1	10 CL	min Chi	NO -	1150	my Gen	eral
	State	31. Dete filed (Month, Dey, Year)	32. Registrar	s Signature	, N		MINISTER	1 1.02	113.7		
	Registrar	JUI 16	1999	wa	9. 1	na	V. 1				



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					Ce	rtificat	e of	Death			Reg. No.	-	1100
		1. Decedent's Neme (First, Mid	idle, Last)							2. Dete of De		Vana	3. Time of Deeth
Physic		NELLIE E	LIZABETH S	AWYER	WIL	SON				July	Dey 16,199	Yeer	2300
/Med Exami		4a Fecility Name (If not institute					1	4b. City, To	wn, or Lo	ocation of Deeth	-	+	
LAUIIII	,,,,,	PENINSULA REGI	ONAL MEDICAL	L CENTER	2			SA	LISB	URY		WICOM	IICO
Funeral		5. Social Security Number	6. Sex 7. /	Age (In yrs. lest	birthday)	If Under		If Under		8. Date of Birt	h Vana)	9. Birthp	olece (Stete or Foreign
Director	Ц	215-26-3975 Usuel Residence of Decedent	1□M <b>2</b> ØF	69	Yrs.	Months	Deys	Hours	Min.	8. Date of Birt (Month, Da 3/4/.	30	Coun	MD_
dend dend		10a. Stete 10b. Coun	ty	10c. City, To	own or Lo	ocation						1	Od. Inside City Limits
Mary	to	MD Wo	rcester	Oc	ean	City							1 ☐ Yes 🏋 No
h the Marylend r 28a-f ehow	Director	10e. Street and Number				10f. Zip	Code				10g. Citizen of	Whet Cour	ntry?
23a or		9723 Steph	en Decatur	Highway	у		2184	2			US	Α	
items items	Funeral	11. Meritel Status	12. Wes Deceder Armed Force	nt Ever in U,S. s?	13.	Was Deced	dent of H	lispenic Ori	gin? (Sp.	ecify Yes or No Rican, etc.)	- 14. Ra Ble	ce - Americ	
5-UUZU 72 hours efter death with the Marylend natural, or items 23a or 28s-f show	by	1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 🔀 Divorce	If Yes, Give			1□ Yes		Specify:				y: wh	
21215-0020 d within 72 hours ef giane. r then "netural", or f the Weddel Evern	Completed	15. Decede (Specify only high	ent's Education lest grade completed)	11	(Give	dent's Usu	rk done	durina mos	t of work	ing	16b. Kind of E	usiness/Inc	dustry
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arylar should by and Manta and Manta umartic ev	70		<u> </u>		OF 14-11							Carte Zie	0-41
F TE G		19a. Informant's Name/Raletion Charles Saw								el Route Numberlin . Ml			(Coda)
Ore First		20a. Method of Disposition 1X Buriel 2 ☐ Cremetion	2 Dameual from Stat	come	of Dispo	osition (Nei metory or c	ne of			Dete	20c. Location	- City or To	own, Stete
Pages nent of ant: If to		4 Donetion 5 Other		Sur	rset	Memo	rial	Park		7/20/99	Berli	in, M	D
Dattimore, pemit. Pages 1 a Department of Hae Important if New any injury or othe once.		21. Signature of Funeral Service	e Licensee		2:	2. Name er			F	Burbage			me
		23a. Pan f. Enter the days as a, shock, or heer failure.	1 Justice	and the death. F	o not on					Berlin,		11	Approximete
/Medical	Examiner	Immadiete Causa (Final diseese or condition rasulting in death)	e. ME	Dua to (or as				Lun	De	CAn	J.CEIN		
OX DS/DU, certificate be axecuted ding physician and use as the burial-transit	Medical Exa	Sequentially list conditions, if eny, leading to immediate causa. Entar Undarfying Cause (Disease or Injury that initiated evants resulting in deeth) Lest	С	Due to (or as									
for the state of	Physician/	Pert II. Other significant condi	dtiona contributing to death	but not resultin	a in the u	underlying o	euse aiv	ven in Part i		23b. Did	tobacco use c	ontributa t	o the causa of death
d by th										10	Yas 2□ No	3 Pro	bably 4 Unknow
200	Completed by									24e. Wes	en eutopsy rmed?	av	Vere eutopsy findings veileble prior to completion of ceuse death?
The law ate has page 2	E									10	Yas 2 No	11	☐ Yes 2☐ No
	BeC	25. Was cese referred to medic	cel					26 Plece	of Deet	h (Check only o	1		
Physician: this certific ral director,	0	examinar?	Hospital: 1 Inpa	tient 2 FB	/Outpetier	nt 3 D	Oth	er.		me 5 Rask		har (Speci	(v)
Phys eral di	i.	27. Mannar of Death	28e. Deta of Ir	njury 28	b. Time o		28c. Injur Wor		alsing He	28d. Describe			,,
Attanding ir death.	atio	1 Natural 5 Pend 2 Accident Invas	ding (Month, L stigation	Dey Year)	Injury	М		Yes 2	No				
OVISION  Tor Attending I after death.  Director: After din by the fune	Certification:	3 ☐ Suicide 6 ☐ Coul	mined   200. Place of t	Injury - At home atc. (Specify)	, ferm, st	reet, factor	y, office			28f. Location (City or To		ber or Rura	al Route Number,
DIVISION  To the Hospital or Attanding I within 24 hours after death.  To the Funeral Director: After completely filled in by the funeral completely filled in by the funeral presents.	edical C	29a. Cartifiar (Check only one) Certify	ring Phyalcian: To the bes in Examiner: On the basis end menner	of exeminetion	dge, deat and/or in	h occurred ivestigetion	et the tir	me, dete en epinion, dea	d plece, th occur	end due to the red et the time,	ceusa(s) and m dete end plece	ennar as s	itated. o the ceuse(s)
o the	¥ e	29b. Signature and little of certif				29	c. Licens	e number	110		29d. Date sign	ed (Month,	Dey, Year)
F 5 F 0		X		101	w. he	1	1	1120	770		Time	1 10	2 1999
		20 Name and address of	a who approlated	- NOW	T	Deiret\	10	1-12			JML,	1 12	2)
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		EMM ANUE L  31. Dete filed (Month, Day, Yea		strar's Signature		20101	4	7,4	00 6	(10 -	21/	-, -, -, 0	1) 113
St Regist		JUL	9 1999	enera	19	. 1	par	KS					

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3 Time of Death Day **Physician** Jacob Edgar Weaver Jr July 20 1999 4:22PM /Medical 4e Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner The Memorial Hospital Easton Talbot 8. Data of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 M 2□ F Months Days Hours Min. Yrs. Director 218-05-2212 83 Nov.1, 1915 Maryland Usual Residence of Decedent the Maryland 10a. State - ehow 10b. County 10c. City. Town or Location 10d. Inside City Limits r 28a-f show 1 Yes 2 No Directo Maryland Caroline Greensboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ma 23a or 21639 Funeral 207 S Main St USA thems ? 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, pemit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hydiene. Important: if Item 27 is marked other then "natural", or then eny Injury or other traumatic event, the Mental Element Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Merried 2 Merried eaver, Jacob Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: p Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Farmer Agriculture 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Jacob Edgar Weaver Sr Pearl Blackburn 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ethel Marie Weaver/Wife 207 S. Main St Greensboro, Maryland 21639 20a. Mathod of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1X Burial 2 Cremetion 3 Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Greensboro Cemetery July23,1999 Greensboro, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fleegle & Helfenbein Funeral Home PA PO Box 160 Greensboro, Maryland 21639 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediata Causa (Final diseasa or condition resulting in death) /Medical RUPTURED ABDOMINAL ADRITIC ANGURACY HOURS Examiner Due to (or as a consequence of): Examin The law requires that the death certificate be executed physician and s the burial-transi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Box 68760. Physician/Medical Due to (or as a consequence of): for use Pert tl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 □ Unknown OF CORON Ary 1 ☐ Yes 2 ☐ No ARTERY Records, 24b. Were autopsy findings available prior to complation of cause of death? Completed 24a. Wes an autopsy performed? certificate has 1 Yes 2 No 1 TYes 2 No of Vital Physician: Be 25. Was case referred to medicat axaminer? 26. Place of Death (Check only one) 1□ Yes 2□ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funarai 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? After or Attending 1 Naturat Division 5 Pending investigation after death.

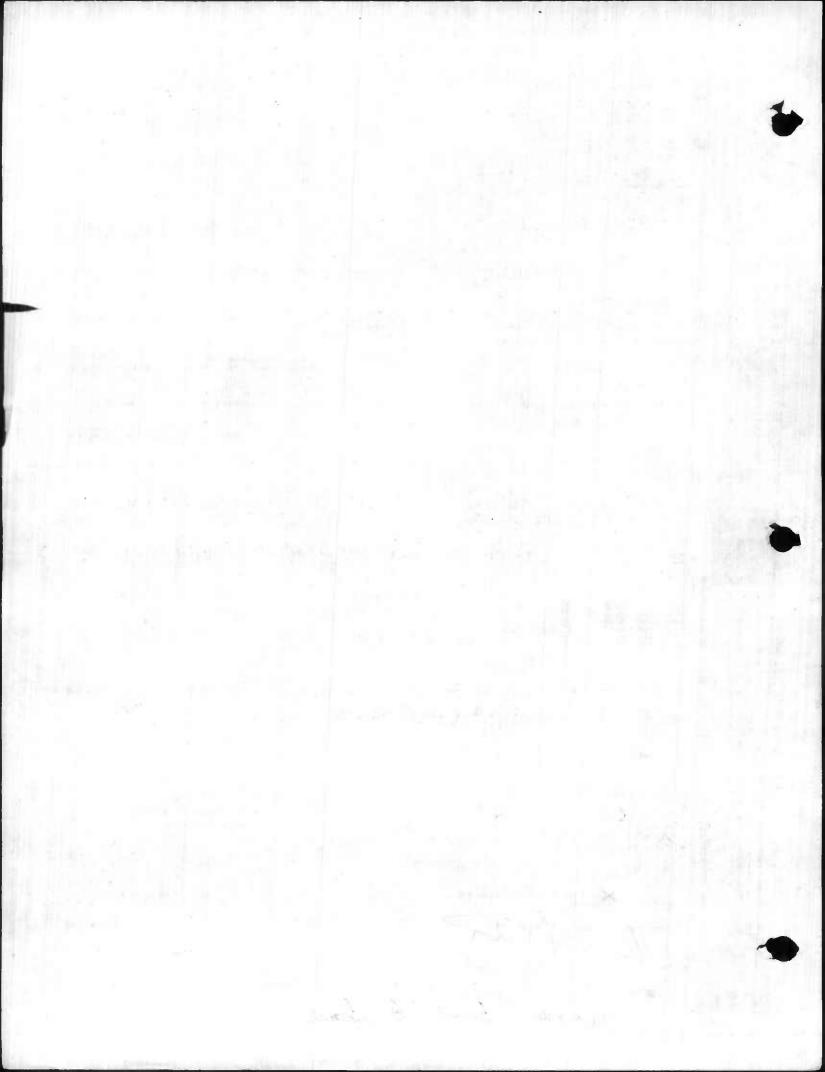
Director: Aft
d in by the fur 1 Tyes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, ferm, street, fectory, office building, atc. (Specify) 4 Homicide filled in within 24 hours a To the Funeral D Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the company of the compa Medical 29a. Certifie refer: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) \$ 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) 0 D 48064 July 21, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kevin Stitely 505 Dutchman's Lane Easton, Maryland 21601 31. Date filed (Month, Day, Year) 32. Registrar's Signature

**DHMH 16 Rev 6/95** 

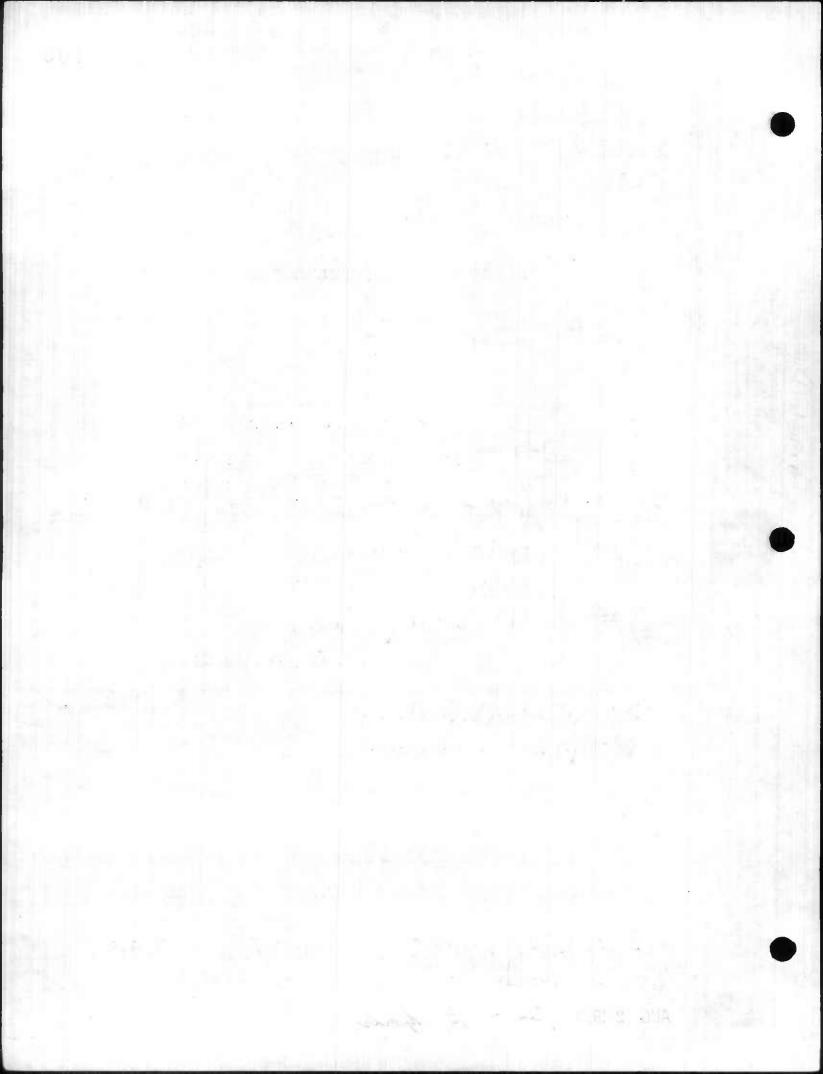
State Registrar

23 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** DORIS DELL 28 1999 4c. County of Death 4b. City, Town, or Location of Death 08:30 PM /Medical 4e Facility Name (If not institution, give street end number) Examiner GREATER BALTIMORE MEDICAL CENTER BALTIMORE TOWSON IT Under 24 Hrs. Birthplace (State or Foreign Country) H Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Deys Months Hours 1 M 2 X F 3/6/28 Director 219-20-5262 71 MISSOURI Usuel Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Nerns 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director BALTIMORE TOWSON 10a. Street and Number 10f. Zin Code 10g. Citizen of What Country? 8111 BARKSDALE ROAD 21286 USA Funerai 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Merital Stetus Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give 1 □ Never Married 2 □ Merried altimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify: WHITE P 3 ₩ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) 12th GRADE HOMEMAKER OWN HOME marked other 17. Fether's Neme /First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JAMES MARION DAVIS MARIE JANE ARTHUR 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 mportant: If item 27 any injury or other to KATHLEEN ARNIEL DAUGHTER 8111 BARKSDALE ROAD TOWSON, MD 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Buriel 2 Cremetion 3 Removel from Stete **Department** DULANEY VALLEY MEM. GAR. 4 ☐ Donetien 5 ☐ Other (Specify) 7/31/99 COCKEYSVILLE, MD 21. Signature/of Funerel Service Licensee 22. Name end Address of Facility
THE JOHNSON FUNERAL HOME, P.A. LOCH RAVEN BLVD. TOWSON, 8521 21286 MD one that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, auto-or each line. . Enter the disease, or complicate, or heert feilure. List only on Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner 100 The law requires that the death certificate be axecuted Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Last Due to (or es a consequence of) Box 68760, Physician/Medicai Due to (or as a conse uence of): ordery dus case P.O. Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No Records, à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an eutopsy 2000 1 ☐ Yes 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physicien: Be 25. Was case referred to medical axeminer? 26. Place of Deeth (Check only one) Hospitel: 2 D.NO Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yas 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1- Netural 5 Pending death. 1 TYes 2 No Investigation 2 Accident 24 hours aftar deat Funeral Director: 6 Could not be determined 28l. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completely (Check only one) within 2 8 29b. Signeture and title of certif 29c. License number 29d. Date signed (Month, Day, Year) W 30. Name and address of person who completed hause of death (Item 23a) (Type, Print) 6701 N C HARLES ST TOU TOWSON MD 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State 1999 Registrar AUG

DHMH 16 Rev 6/95



Plea	ase Type or	Print In	Black in	delible	Ink	Assı	ire A	II Coples	s Are	l ea	ible.		
		of Marylan	nd / Depa		t of H	lealth a	and M			ne Q C	9 2	I, I	06
1. Decedant's Nama (First, Middle	la, Last)							2. Date of De	eath			3. Tir	ma of Deeth
	Beatrice		xander	<u>c</u>				Month TULY	1 2	_	1999	6	6.40 pm
4a Facility Name (If not institution GOOD SAMA)	RITAN 1	HOSPIT				BA	ALT,	ocation of Deat	ith 40	Ic. County NA			
5. Social Security Number 216–28–1312	6. Sex 1 ☐ M 2√2 F	7. Age (In yrs. 70	: last birthday) Yrs.			If Under Hours	Min.	8. Date of Bir (Month, De 09-29	orth ay, Year 9-21	3	9. Birthple Count V A	ace (Str	tate or Foreign
Usual Residence of Decedent		102.0	7 221								T.		
MD 10b. County		1	ity. Town or Lo ltimor								10		ide City Limits Yes 2 □ No
10e. Street and Number				10f. Zip (	Code				10g. C	itizan of	What Count	try?	
1648 Burnwood	d Road			212						USA		.,	
11. Marital Status		cedent Ever in U	15 13			tispanic Or	igin? (St	pecify Yes or No			ce - America	en India	an
1 Never Married 2 Marr 3 Widowed 4 Divorced	Armed Fo	Forces? 2 XNo Sive	1	if Yas, speci 1 ☐ Yas 2	cify Cuba	Specify:	n, Puarto	o Rican, atc.)	,		eck, White, e		
15. Decedent (Specify only highes	nt's Education est grade completed)	)	16a. Decer (Giva life.	edent's Usuai a kind of work DO NOT use	i Occup rk done	ation during mos	st of work	king	16b.	Kind of B	Business/Inde	lustry	
Elementary/Secondary (0-12) 12th Grade	2yrs.	(1-4or 5+)		istra		ırse					ing Co	0.	
17. Father's Neme (First, Middle, Emmitt	Ellis						er's Name nnie	ne (First, Middle		<sub>en Suman</sub> bert			
19a. Informant's Name/Relations Andrea Mo	ship (Type, Print) oseley							nral Route Numb					
20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		State	Place of Dispo cemetery, crem altimo	matory or oth	ther plec		, 0	Date 08-02-9			- City or Tov		
21. Signature of Funaral Service	Licensee	')		2. Name and				altimo					
23a. Part1. Enter the disease, or shock, or heart feilure. List	complications that conly one cause on	caused the deat								10		Approx	
Immediate Cause (Final disease or condition resulting in death)	a. <u>4</u>	YPOXI	/ C E	FNCE	=PH	HLO	PAT	THY			1		
	b. 15	CHEN	MIC	EN		PHA	LOF	PATHY	/				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			or es a conseq										
that initiated events resulting in death) Last	d	Dua to (o	or as a conseq	uence of):									
Part ti. Other algnificant conditio	one contributing to d	Jeath but not res	sulting in the u	undarlying or	eusa giv	en in Part	1.	23b. Die	d tobacc	o uaa cc	ontribute to	the ca	nusa of death?
DIABETE	-s M	ELUT	US					10	Yas :	2□ No	3 Prob	ably	4 Unknown
								24a. Was	s an auto formed?		ava	ailable p	n of cause
								10	Yes 3	3/2/No	10	Yes	212 No
25. Was case referred to medical examiner?							e of Dear	th (Check only					
1 Yes 2 No	Hospital:	Inpatient 2□	☐ ER/Outpatien	nt 3 DO/	Oth	er: 4 Nu	ursing Ho	ome 5□Resi	sidence	6 □Oth	her (Specify	1)	
27. Manner of Death  Netural 5 ☐ Pending	28a. Data (Mon	of Injury nth, Dey Year)	28b. Time of Injury	25	8c. Injun	y at k?		28d. Describe	how inj	ury occur	rred		

Physician /Medical Examiner

To the Mospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the tuneral director, page 2 should be detached for use as the burta-fransit

Division of Vital Records, P.O. Box 68760,

Examine Sequentially if any, leading cause. Enter Cause (Disea that initiated of resulting in de Completed by Physician/Medical Part ti. Other 25. Was case examiner Be

**Funeral Director** 

To Be Completed by

**Physician** 

/Medical

Examiner

**Funeral** 

Director

permit. Peges 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic avent, the Medical Examinal must be notified at

Baitimore, Maryland 21215-0020

Medical Certification: To 27. Manner of

Investigation

Netural 2 Accident 6 Could not be determined 3 Suicide 4 Homicide

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

JC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29c. Licensa number 29d. Data signed (Month, Day, Year)

29b. Signature and titla of certifian

29a. Certifier (Check only one)

ANU GABA MD

P-12560

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANV GABA, RESIDENT, GOOD SH SAMARITAN HOSPITAL BALTIMORE, MD

State Registrar 31. Date filed (Month, Day,-Year)

32. Begistrar's Signeture

**DHMH 16 Ray 6/95** 

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#### State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Name (First, Middle, Lest) **Physician** BALLMAN DOROTHY ELIZABETH /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street end number) Examiner NORTH ARUNDEL HOSPITAL 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) **Funeral** 1 ☐ M 2 💢 F 212-20-9026 73 Director Usual Residence of Decedent the Meryland 10s. Stete 10c. City, Town or Location 10b. County ahow 7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Medical Examiner, must be notified at GLEN BURNIE Directo MARYLAND ANNE ARUNDEL

(	GLBA	VBU	RNIE	2	Ann	E	ARUND	EL
/ear	If Under		8. Date of B	irth .	(0.00)	9.1	Birthplece (Stete of Country)	r Foreig
ays	Hours	Min.	MAY 13				ARYLAND	

Day

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1999

14. Rece - American Indien, Bleck, White, etc.

20c. Location - City or Town, State

ELKRIDGE, MD

3. Time of Death

10d. Inside City Limits

1 ☐ Yes XIX No

1-50Pm

2. Dete of Deeth

AUG UST

10e. Street end Number

10g. Citizen of What Country? 10f. Zip Code 21061 UNITED STATES

306 ROOSEVELT AVE. 12. Was Decedent Ever in U,S. Armed Forces? 11. Merital Status 1 ☐ Never Married 2 ☐ Merried 1 ☐ Yes 2 No If Yes, Give 3 Widowed 4 Divorced

1 ☐ Yes 2 ☑ No Specify: Specify: WHITE 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) 10 17. Fether's Name (First, Middle, Last)

OWN HOME 18. Mother's Neme (First, Middle, Maiden Surname)

GILBERT L. LEISHER 19a. Informent's Name/Relationship (Type, Print)

EMMA A. ROBERTSON 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)

SYDNEY BALLMAN/HUSBAND 20e. Method of Disposition

306 ROOSEVELT AVE. GLEN BURNIE, MD 21061 AUG. 5, Date

1999

4 Donation 5 Other (Spanis) MEADOWRIDGE MEM. PARK 21. Signature of Funeral Service License

1 ☐ Burlel 2 ☐ Cremetion 3 ☐ Removel from State

22. Name end Address of Fecility
KIRKLEY-RUDDICK FUNERAL HOME P.A.

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

0 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line.

421 CRAIN HWY. S.E. GLEN BURNIE, MD 21061 Approximate Interval Between Onset end Deeth

Immediate Ceuse (Finel disease or condition resulting in deeth)

A CUTE MY OCARDIAL INFARCTION

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

THEROSCIEROTIC CORDIVARY VASCULAR
Due to (or es e consequence of):

DISEASE

DIADETES MELLITUS

Due to (or es e consequence of):

HOMEMAKER

cemetery, cremetory or other plece)

20b. Place of Disposition (Neme of

PNEUMONIA

Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting In deeth) Lest

Part II. Other significant conditions cont

ibuting to death but not	resulting In the	underlying caus	e given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24e. Wes en eutopsy performed'

24b. Were autopsy findings eveileble prior to completion of cause of deeth?

1 ☐ Yes 2 No

1 ☐ Yes 2 XNo

25. Wes case referred to medical examiner? 1 Yes 2 No 27. Menner of Deeth

5 Pending

Investigation

1 SNatural

2 Accident

4 - Homicide

3 Sulcide

29a, Certifier

28e. Dete of Injury (Month, Dey Year)

Hospitel: 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury et Work? 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

26. Piece of Deeth (Check only one)

6 Could not be determined 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

281. Location (Street end Number or Rurel Route Number, City or Town, State) To kertifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the ceuse(s) and manner as steled.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date end place, end due to the ceuse(s) end manner stated.

29b. Signature end title of cartifie

29c. License number D5 1664 29d. Date signed (Month, Day, Year)

AUGUST

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUDHIR KUMPR BEGREWAL 21061
NORTH ARUNDEL HOSPITAL, 301 HOSPITAL DRIVE, SIEN BURNTE MD 21061 32 Blance's Signature 31. Dete filed (MA) 6ay, Y2r) 1999

State

Registrar

DHMH 16 Rev 6/95

DOROTHY

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Completed

and Mental Hygiene.

Pages 1 and 2 should be fill ment of Heelth and Mental H

**Physician** /Medical

Examiner

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Sign

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Hospital or Attending 24 hours effer deeth. Funeral Director: Afte

24 hours

To the Within 2

thet the death certificate be executed

Records,

Division of Vital

Examiner

Physician/Medicai

by

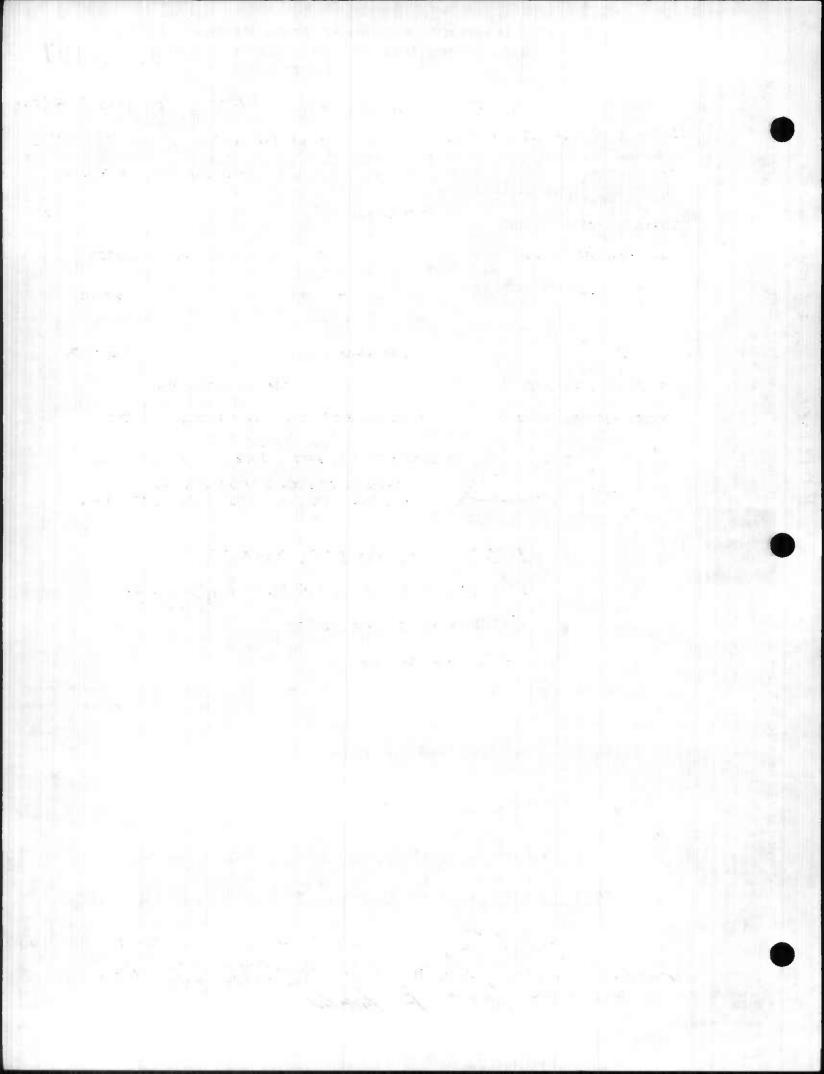
Completed

Be

Certification:

edicai

Baltimore, Maryland



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Blackburn Month 7:5 31 6 An 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth General Hospital Columbia Howar ward (unt If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)

7 20 - 1939 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 5. Social Security Number 10 M 200 F 9 251-58-0290 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Kridg 10a. Street and Number 10f. Zin Code 10g. Citizen of What Country? 21075 U.S.A Parkwai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indien, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 1 ☐ Yes 2 DONo Specify: Black Specify: 3 XWidowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) PHSON Elementary/Secondary (0-12) Cotlege (1-4or 5+) 12th grade NA orrectional Officer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Eddie Bess Myers 110 11mmons 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address, (Street and Number or Rural Route Number, City or Town, State, Zip Code) lumbia, Md 21046 10083 Terrace zeorge Hax Dun 1an 20b. Place of Disposition (Name of cemetery, cremetory or other plece)

Metro Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removel from State atonsville ma 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Name and Address of Facility 22 West 21215 arch VOK. Va Ho, Md 4300 Wabash 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervat Between Onset and Death immediate Cause (Final neumonia disease or condition resulting in death) Due to (or es a consequence of): Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of): preuman Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 🗆 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 NInpatient 2 ER/Outpatient 3 DOA 27. Menger of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Examiner Examiner be executed P.O. Box 68760, Physician/Medical Records, ģ Be Completed certificate Division of Vital Medical Certification: To

Physician

/Medical

**Examiner** 

**Funeral** 

Director

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filed within 72 hours after

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

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il Hygiene. other then "natural", or Nerna 23a or 28a-f show vent, the Medical Examiner must be notified at

permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: if them 27 is marked oth any Injury or other treumstic event RABA

**Physician** /Medical

 Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifica To the Hospital or within 24 hours att To the Funeral Di completely filled in

State

Registrar

1th Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signalize and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

m. mi) Name and address of person the completed cause of death (Item 23a) (Type, Print) 11055

35 アバリ

31 Little Patirent

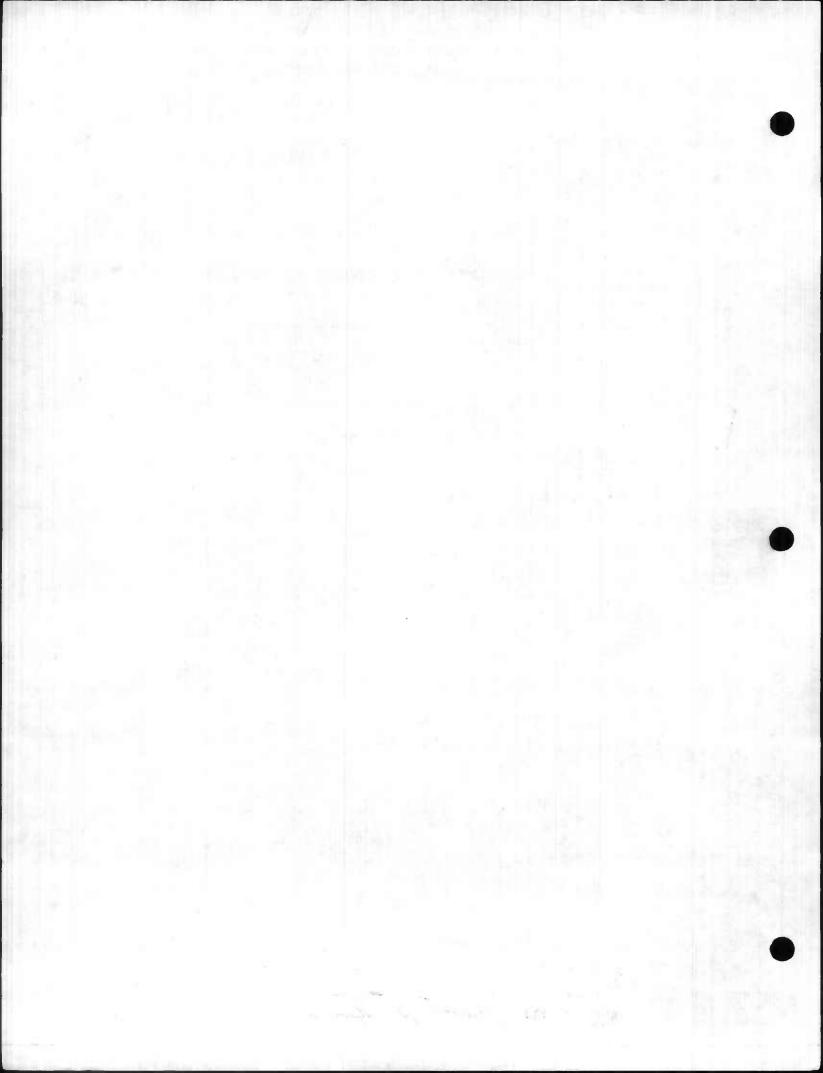
31. Date filed (Month, Day, Wast)

DAVID JACKSON

4 Homicide

29e. Certifier

MI Surte #210 Columbia, mi) 32. Registrar's Signatu



1 Neturel
2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

29b. Signeture and le of cartifier

Director

To Be Completed by Funeral

**Physician** /Medical

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Menyland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or items 23s or 28s-f show any injury or other traumatic event, as Modical Examiner must be inclined an once.

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		State of M	Maryland		artment of H rtificate of	Health and I Death		giene 9	2411	19			
1. Decedent's Name (Firs ALE	st, Middle, Last EKSAND				CHUMIK		2. Date of Deat Month		Year 12	ime of Death			
4a Fecility Name (If not in	tospro	of of	BAHIN	nu	If Under 1 Year		TOPE	4c. County	N/A	Famign			
5. Social Security Number 217–25–9246	5 10	ex □M 2IXF	Age (In yrs. las	6 Yrs.	Months Days	the second second second second		(, Year)	9. Birthplaca (Si Country)	JKRAINE			
Usual Residence of Dece 10a. State 10b.	County N/A			Town or Loc						ide City Limits			
10e. Street and Number				ili I I I I I I	10f. Zip Code		1	10g. Citizen of W					
5900 PARK	HEIGHTS	S AVENUE  12. Wes Decede Armed Force	ent Ever in U,S.	. 13. )	Was Decedent of	21215 Hispenic Origin? (Sban, Mexican, Puert	Specify Yes or No-	14. Race	U.S.A.  14. Race - American Indien, Black, White, etc.				
1 Never Married 2	2XXMarried Divorced	1 Yes 2 If Yes, Give	X No		1 ☐ Yes 2 No		O'I Waren	Specify: WHITE					
(Specify onl	Decadent's Edu nly highest grad / (0-12)			(Give I life. D	DO NOT use retire	e duning most of wor ed)			usiness/Industry				
12 17. Father's Name (First,	Middle, Last)				HOUSEWIFE	18. Mother's Nen	ome (First, Middle, M		ne)				
GEORGE  19a. Informant's Name/R YAKOV DEKH					ng Address (Stree	KATHER at and Number or Ru IGHTS AVE	Rural Route Number	r, City or Town,		)			
20a. Method of Dispositio	on emation 3 🗆 f	Removal from Sta	20b. Plac	ne of Dispos	osition (Name of matory or other pla	1	Date	20c. Location -	- City or Town, Sta	ate			
21. Signatura Funeral	llau/	Le-		8	2. Name and Address	ress of Fecility	SOL LEY	VINSON (	& BROS.,	INC. 21208			
23a. Part 1 Enter the dis- shock or heart failu	ure. List only to	offe clause on each	ch line.			ying, such es cardiad	c or respiratory en	est,	Interve	et Between t and Death			
disease or condition resulting In deeth)		a. Hype	Due to (or a	21A as a conseq	(uence of):								
Sequentially list conditlor if any, leading to immedic cause. Enter Underlying Cause (Dissess or Injury that Initiated events resulting In deeth) Lest	ens, iate	c. SASTRE		as e conseq	quence of):	)							
Part II. Other significant								obacco use cor	ontribute to the ca	ause of death?			
Eno Stage Man Instit	Depe	- Duess noent D	10598	Spiller Me	Ilins,	SEPSIS	24e. Wes e	en autopsy rmed?	24b. Were auto available completio of death?	prior to on of cause			
	,					•	1 🗆 Y	/(	1 Tes	26 No			
25. Was case referred to examiner?  1 Yes 2 No	-	Hospital: 12 Inpe		R/Outpatien	nt 3LI DOA	other: 4 ☐ Nursing H	Home 5 Reside	denca 6 Oth	her (Specify)				
27. Menner of Deeth 1 Neturel 5	Pending	28e. Dete of I	Injury 2: Day Year) 2:	28b. Time of Injury	of 28c. Inju	ury et ork?	28d. Describe h	now Injury occurr	red				

**Physician** 

/Medical **Examiner** 

> Completed by Physician/Medical Examiner Medical Certification: To Be

To the Funeral Diractor: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be deteched for use as the buriel-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Diractor: After this certificate hes

> State Registrar

ANDREW 31. Dete filed (Month, Day, Year)

1999

5 Pending Investigation

6 Could not be determined

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) 32. Registrer's Signeture

28e. Place of injury - At home, ferm, street, factory, offica building, etc. (Specify)

29c. License number

1 Yes 2 No

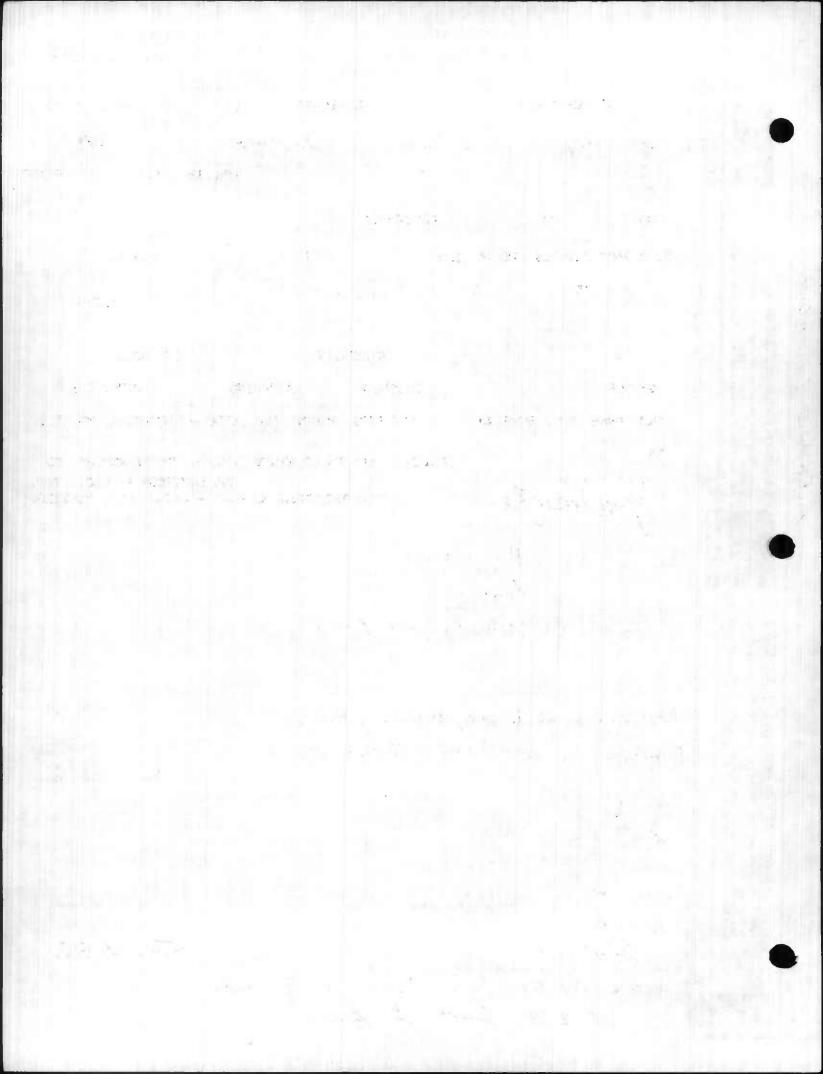
Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29d. Dete signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

**DHMH 16 Rav 6/95** 

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# Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene

A.c.a.			,	Certifica	ate of D			Reg. No.	241	10			
Physician /Medical	Decedent's Name (First, Middle, La     ERNES T     4a Facility Nama (If not institution, gi			C	LIN	JTON . City, Town, or	2. Data of De Month	30 19	ggg /	Tima of Death O: 30Am			
Examiner	Good Samarita		1			Baltim		NA					
Funeral Director		Sex 7. Age (	(In yrs. last birt	hday) If Unc Month		If Under 24 Hrs. Hours Min.	8. Data of Bir	th. Year)	9. Birthplaca Country)	(Stata or Foraign NC			
the Maryland 28a-f show sofflied at ector	10a. Stata 10b. County	NA I	Balti							nside City Limits  Yas 2 □ No			
D Po	10e. Street and Number 5611 Govane Av	venue	1 4	10g. Citizen of V USA	What Country?								
	11. Marital Status  1 Novar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 21 No If Yes, Give Year or Dates:			panic Origin? (S , Mexican, Puert Specify:	pecify Yes or No o Rican, atc.)	14. Rac Blac Specify	e - American Inck, White, etc.	ite, etc.				
within and be Men	15. Decedent's E (Specify only highest on Elementary/Secondary (0-12) 6th Grade	ducation ade completed) College (1-4or 5+) NA		Decedent's Us (Give kind of the DO NOT Drive:	work done du use retired)	ion Iring most of wor	king		usiness/Industry	Race Track			
tal Hygin d other event, it	17. Father's Nama (First, Middle, Last	)				18. Mother's Nan	na (First, Middle	, <i>Maiden S</i> uman	na)				
Merus build b	Joseph	Clinton	Viola		Le	ee							
d 2 sh d 2 sh d and 7 is m treum	19a. Informent's Neme/Relationship			er, City or Town,									
Definitions, Notes and Separation of Health Apparation of Health Important; if Item 27 my Injury or other trings.	Marion Miles-Ingram  5611 Govane Avenue Baltimore, Mary  20a. Mathod of Disposition  1 Buriat 2XIC cremation 3 Removal from State 4 Donation 5 Other (Specify)  5611 Govane Avenue Baltimore, Mary  20b. Place of Disposition (Name of cemetery, cremetory or other place)  Greenmount Cemetery 08-02-99 Balti												
permit. Peparmimportar importar any injur	21. Signature of Funeral Service Lice			22. Nama	and Addrass	of Facility B	altimo	re, Man E. Nort					
Physician /Medical Examiner	23a. Pan't. Enter the disease, or comshock, or heart feilure. List only immediata Causa (Final disease or condition resulting in death)	a	e death. Do n	S		, such as cardiad	or respiratory a	rrest,	Intar	roximate rval Between at and Death			
ifficate be executed g physician and as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.												
5 0 6	Cause (Disease or injury that initiated events rasulting in death) Last  Due to (or as a consequence of):  d.												
at the death certified by the attending stached for use a Physician/M	Part it. Other significant conditions of	n in Part I.	23b. Did	tobacco use co	ontribute to the cause of death?								
, # e	HYPERTEN	SION			ETE.		10	Yes 2□ No	3 Probably	4 Dunknown			
aw requir us been s 2 should								an autopsy ormed?	available	utopsy findings e prior to tion of cause 17			
= - 56 0							10	Yas 200 No	1 ☐ Yes	2 DNG			
iclani certific rector	25. Was casa refarred to medical axaminer?	28. Place of Deeth (Check only one)  Hospital: Other Advanced Control of Cont											
5 & E	1 ☐ Yas 2 D No 27. Manner of Death	28a. Data of Injury (Month, Day Y			28c. Injury Work	4 LI Nursing H		dence 8 □Oth how Injury occur					
To the Hospital or Attending P within 24 hours after death completely filled in by the funer Medical Certification:	1 🖾 Neturat 5 🗆 Pending 2 🗀 Accident investigatio 3 🗀 Suicide 6 🗀 Could not b 4 🗀 Homicide determined	n Plant Main	28f. Location (Street and Number or Rural Routa Number, City or Town, State)										
No Hospital or no 24 hours after no Funeral Dir pletely filled in edical Cert	29a. Certifier 1 Certifying Pt (Check only 2 Medical Exer	nyaician: To the best of r	my knowledge, camination and	death occurre	ed at the time on, in my opi	, data and place nion, deeth occu	, and dua to tha rred et the time,	causa(s) and ma date end place,	annar as stated. and due to the	cause(s)			
To the comple	29b. Signature and title of certifier	LL MAINTEN STATE	<b>u</b> .	2	PIIC			29d. Data signe	d (Month, Day,	Year) 99			
	30. Name and address of person who	completed cause of deep	th (Item 23a) (I	Type, Print)	n Bo	m P	halt'm	J J	1021	2.39			
State	11. Date filed (Month, Day, Year)	32. Registrar's	s Signature	- 1			JUL LIVING	UK / (	0 ~ 1				



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death arter 8:00 A. M OUSIUS 07 99 26 4a Facility Neme (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Deeth Baltimore | Bultimore | Hunder 1 Year | Hunder 24 Hra. | 8. D Gelston Drive 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) 1 M 2 F 9 7-01-Yrs. Ma 040 -10-1409 **Uauel Residence of Decedent** 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md NA Baltimore 1 Yes 2 No 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 U.S. Drive 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yea 2 ☑ No If Yes, Give / Year or Detea: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien Bleck, White, etc. 11. Merital Status 1 Never Merried 2 Merried 1□ Yes 2□ No Specify. Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Bethlehem Steel Elementary/Secondary (0-12) College (1-4or 5+) th grade Fitter 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Jum es Carty art 19e. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, Stete, Zip Code) Dertha Wita Baltimore, red 21229 we 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Deta 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from State Park Cemetery 7-31-99 4 Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility Jarch F.H. West 4300 Wabash Henre Balto, Md 21215 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Deeth Immediate Cause (Finel disease or condition resulting in death) infarction Due to (or as a consequence of) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of): Due to (or es a consequence of). Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown get disease 24b. Wera autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 PNo

**Physician** /Medical Examiner

Department of important: If any injury or

**Physician** 

/Medical

Examiner

Director

Completed by Funeral

**Funeral** 

Director

28a-1 must be notified

Pages 1 and 2 should be filed within 72 hours after then of Health and Mental Hygiene.

ant: if them 27 is marked other than "matural", or itse ury or other traumatic event, the Medical Examples.

Baltimore, Maryland 21215-0020

the this certificate hes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director,

The law requires that the death certificate be executed

Box 68760.

Division of Vital Records, P.O.

Examiner Certification: To

Physician/Medical Be Completed by

edical

27. Manner of Death 1 WNetural 2 Accident

29e. Certifier

3 ☐ Suicide 4 Homicide

5 Pending investigation 6 ☐ Could not be

28a. Date of Injury (Month, Day Year)

28b. Time of 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

BALTIMORE MD 21229

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. (Check only one) 29b. Signature and title of certifie house

M.D

N. WILTON

29c. License number 047804 29d. Deta signed (Month, Day, Year) 07/27/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MROWIEC 31. Dete filed (Month, Day, Text)

32. Registrac's Signature

530

ITR

State Registrar

ingular and the second

Please Type or Print in Black indelible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death 30 H **Physician** CRAIG 8:35 Pm FRANCES M. JULY /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Northwest Hospital Center Randallstown Baltimore If Under 24 Hrs. 8. Dete of Birth (Month Day, Yeer)
Feb. 18, 1915 5. Sociel Security Number If Under 1 Year Birthpleca (State or Foreign Country)
 England 6. Sex 7. Age (In yrs. last birthdey) **Funeral** Deys 1□ M 2♥F Months 84 216-18-7151 Yrs. Director Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Directo Md. Baltimore Reisterstown 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? With 122 Nicodemus Rd. 21136 U.S.A. Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ∰ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. 11. Maritei Stetus Bleck, White, etc. Pagas 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Ite 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: PV Specify: 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) 12 Administrator Social Security Adm. 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Thomas Nichols Mary Mennon 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) James E. Ripley, Jr. - Nephew 122 Nicodemus Rd., Reisterstown, Md. 21136 other 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 20 1 Burial 2 Cremetion 3 Removel from State permit. Paga Department of Important: If any Injury or once. Meadowridge Mem. Park Aug. 3, 1999 Baltimore, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22. Name end Address of Fecility Eckhardt Funeral Chapel 23a. Pent. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Md. Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final PULMONARY DISEASE · CHROMIC OBSTRUCTIVE disease or condition resulting in death) Examiner Due to (or es e consequence of) Examiner physician and the burial-transit Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): physician Physician/Medical Due to (or es e consequence of): attending p 88 P.O. ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown DIABELES MELLITUS p 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed 24a. Wes en autopsy Deen paga 2 1 Yes 2 No 2 No 1 Yes certificate Division of Vital funeral director, Be 25. Wes case referred to medical exeminer? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1

Inpatient 2 □ ER/Outpatient 3 □ DOA this 27. Menner of Deeth 28d. Describe how injury occurred Certification: 28e. Dete of tnjury (Month, Dey Year) 28b. Time of 28c. tnjury et Work? Hospital or Attending P
 24 hours after death.
 Funeral Director: After t After 1 Neturel 5 Pending 1 Yes 2 No investigetion 2 Accident 6 Could not be determined To the Hospital or Atterwithin 24 hours after der To the Funeral Director completaly filled in by the 3 Suicide Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of tnjury - At home, ferm, streel, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete and plece, and due to the cause(s) end menner steted. 29a. Certifier Medical 29b. Signature and the co 29c. License number 29d. Dete signed (Month, Dey, Year) pertifier 30 ann JULY 1999

3745 FOXFORD

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STOREAM RA

mp 21236

State Registrar

DHMH 16 Rev 6/95

30. Neme end edit

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HALLI

person who completed cause of deeth (Item 23e) (Type, Print)

32. Registrar's Signeture

HARISH:

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Chicago Lucy of 1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Day mand PM Juli 30 4a. Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death Bout more
If Under 24 Hrs. 8. Data If Under 1 Yeer 8. Data of Birth (Month, Day, Year) 16-1916 5. Sociel Security Number 7. Aga (In yrs. last birthday) 9. Birthpiace (Stata or Foreign Deys Months Hours 1□M 2▼F 579-22-3249 82 Yrs Virginia Usual Rasidence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. N/A Baltimore 1 Yas 2 □ No 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country 4401 Roland Avenue 21210 USA 12. Was Decedant Ever in U,S. Armed Forcas? 1 ☐ Yas 2 No if Yas, Giva Yaar or Dates: Was Decedant of Hispenic Orlgin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Raca - Amarican Indian, Black, White, atc. 11 Marital Status 1 Nevar Married 2 Married 1 ☐ Yas X No Specify: Specify: Black 3 Widowed 4 □ Divorced 15. Decedant's Education (Specify only highest grada completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) 12 th Collage (1-4or 5+) 6 Years Teacher Education 17. Fathar's Name (First, Middla, Last) 18. Mothar's Name (First, Middla, Malden Sumeme) David Higginbothan Amanda McDaniel 19e. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Charlene Gregg (Cousin) 7736 Rockledge Ct. Springfield Va. 22152 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of cemetary, cramatory or other placa) 20c. Location - City or Town, Steta Dete 1 Burial 2 Cramation 3 Ramovel from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Woodlawn Cemetery 7/3/99 Woodlawn, Maryland 21. Signeture of Funaral Servica Licansaa 22. Nama and Address of Facility Caple Funeral Service Hennis 5502 Winner Ave. Balto., Md. 21215 23a. Pert1. Enter the disease, or complications that caused tha daath. Do not enter the moda of dying, such as cardiec or respiretory arrest, shock, or haart failura. List only ona causa on each lina. Approximata Intervel Batween Onset end Deeth Immediate Cause (Final ukurwh diseese or condition resulting in daath) Atherosclerosis Sequantially list conditions, if eny, laading to immadiata causa. Entar Undarfying Ceusa (Disaasa or Injury that initiated avants rasulting in death) Last Dua to (or es a consequence of) Dua to (or es e consequenca of) 23b. Did tobacco use contributs to the cause of death? 3 Probably 4 ☐ Unknown 1 ☐ Yss 2 ☐ No hestory coronaly antery hypass 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? and unitral malue replacement. complation of causa of daath? 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No

**Physician** /Medical Examiner

physicien

signed by

certificate

24 hours ele Funeral D

To the Hosp within 24 hou To the Fune completely fil

The law requires that the death certificate be executed

P.O. Box 68760,

Records,

Division of Vital

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

28a-1 show

Director

Funeral

by

Completed

Be

7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at

Hygiene.

parmit. Pages 1 end 2 should be file Department of Heelth and Mental Hy Important: if flem 27 is marked other any injury or other traumatic event 9008.

death with the Merylend

filed within 72 hours efter

Maryland

Baltimore,

Examiner Physician/Medical þ page 2 should be Completed napital or Attending Physician: The hours efter death.

neral Director: After this certificate yfilled in by the funeral director, pa Be P 27. Mannar of Daath Certification:

Medicai

State

Registrar

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Venientia 25. Was casa refarred to predical

26. Place of Death (Check only ona)

Othar: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Inpatiant 2 ER/Outpatiant 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Tima of

1 Natural 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be datarmined 3 Sulcide

28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Specify)

28f. Location (Streat and Number or Rural Route Number, City or Town, Steta)

1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end piece, end dua to the causa(s) and manner as steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, dete and piece, end due to the causa(s) and manner stated. 29a. Cartifiar

M. Dabelle hac grean M.D

29c. Licansa number

29d. Data signed (Month, Day, Year)

30. Nama and addrass of person who complated cause of deeth (Itam 23a) (Type, Print)

700 W. 40 % STREET, BALTIOTORE, 671) 21211 MACGREGOR, KESWICK, BRASELLE

31. Date filed (Month, Day, Yaar)

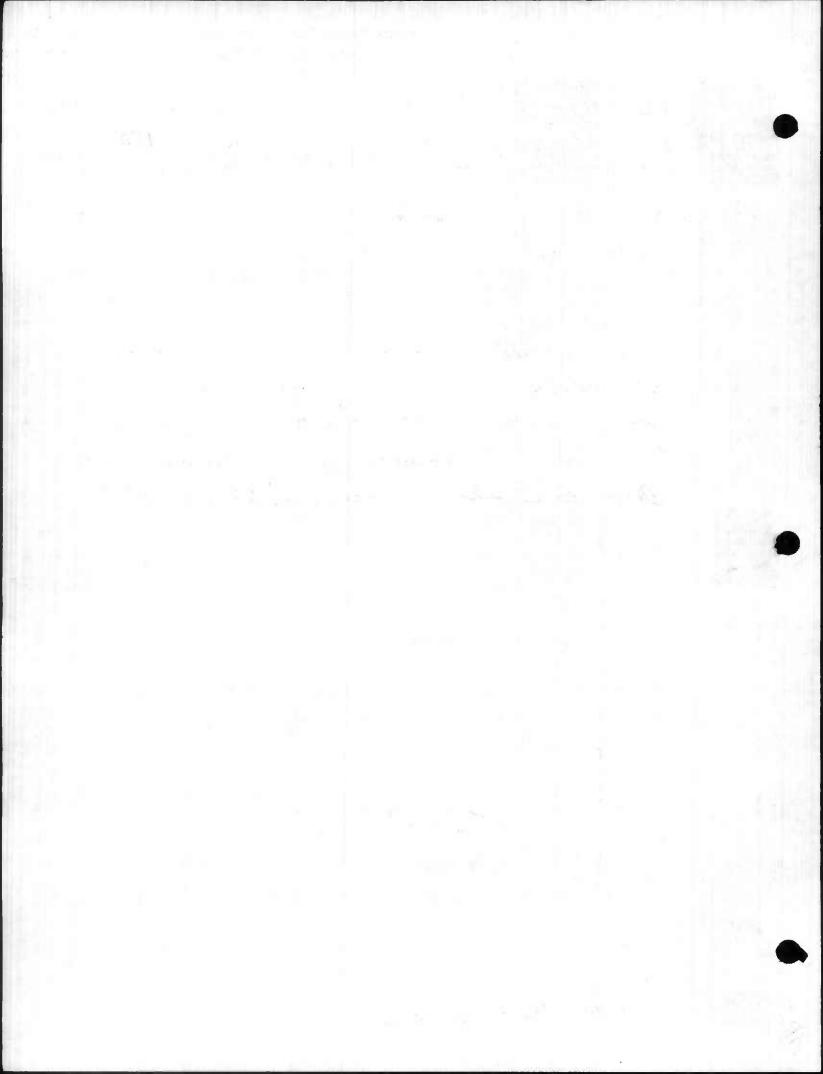
29b. Signatura and titla of certifier

1 Yes 2 No

4 Homicide

2 1999 RUG

32. Registrar's Signatura

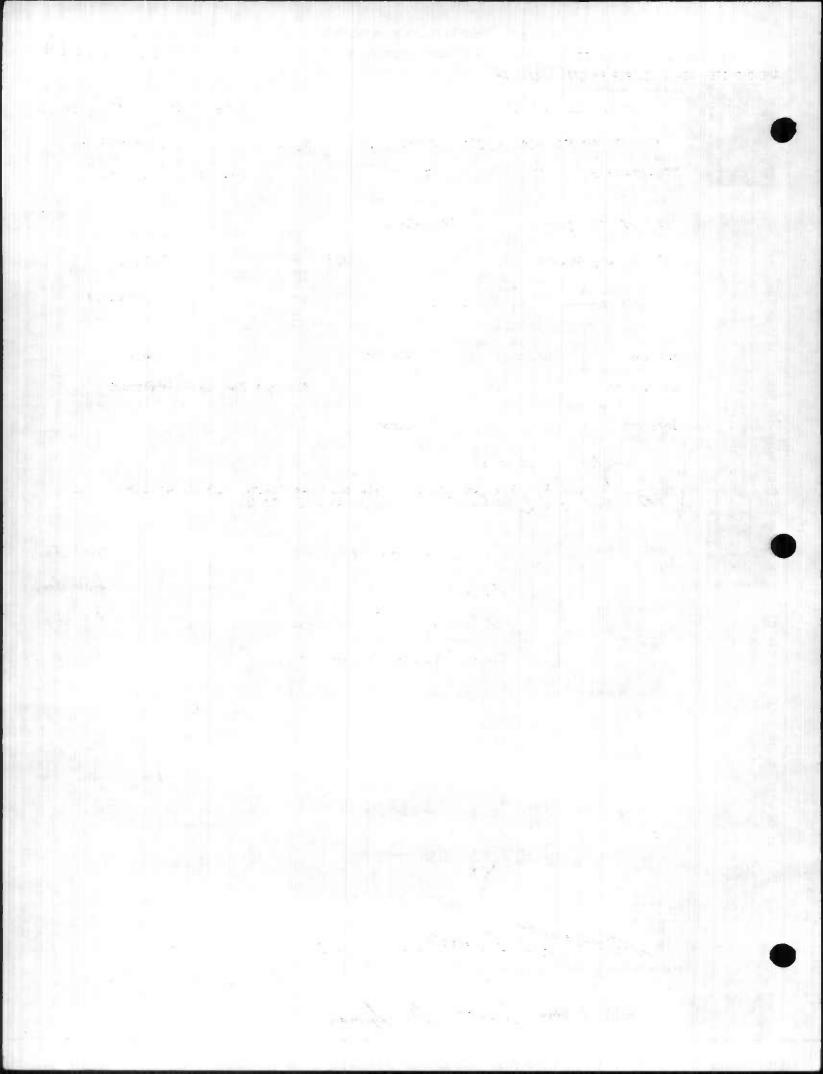


State Registrar 31. Dete fited (Month, Day, Year)

AUG 2 1999

32 Registrer's Signeture

Spark



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** 1)000 Harold 10:35pm 1999 /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not Institution, give street and number) 4c. County of Death Examiner Manor Care Nursing Home Baltimore if Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 04-20-21 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 □ F Days Hours Min. 88 PA 164-18-8217 Director Usual Residence of Decedent 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits **ahow** the Mayla r than "natural", or liers 23s or 28e-f show the Medical Examiner must be notified at MD NA Yes 2□ No Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4669 Falls Road 21209 IISA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Black, White, etc. hours after 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: Black à If Yes, Give Yeer or Detes: 3€Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Eiementary/Secondary (0-12) College (1-4or 5+) G.A.F. Company 12th Grade NA Driver 17. Father's Name (First, Middle, Last) 16. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nant of Health and Mental until Itans 27 is marked of Amy Nathaniel Isaac DOW 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19050 19a. Informant's Name/Relationship (Type, Print) artment of Health a prisent: If item 27 is 1122 Whitby Avenue Yeadon, Philadelphia Carol Dow 20b. Plece of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 □ Burla1 2 □ Cremetion 3 □ Removal from State 6 Ferris Crematory 07-30-99 Wentchester, PA 4 Donation 5 Dother (Specify) 21. Signeture of Funeral Service Licensee Baltimore, Maryland 21202 22. Name and Address of Facility entry WM.C.March FH 1101 E. North Avenue eles Part1. Enter the disease, or complications hat caused the desire shock, or heart feilure. List only one caused on each line. Approximate Interval Between Onset end Deeth To not enter the mode of dying, such as cardiac or respiratory arrest, Physician Cerebro Vagcular Acerdent /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or es a consequence of) Examiner pertension tha burial-transit Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last and Due to (or es a consequence of): physician Physician/Medical Due to (or as a consequence of) use as attending signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contributa to the causa of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown by 24b. Were autopsy findings avellable prior to 24a. Was an autopsy Completed peed completion of ceuse of death? 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No certificata Attending Physician: funeral director, Be 25. Was cese referred to medical 26. Place of Deeth (Check only one) Other: 4 Hursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28e. Date of Injury (Month, Day Year) Affer 1 Netural 5 Pending 24 hours after death. Funeral Director: After 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours 1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as steled.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29e Certifier To the Hosp within 24 hou To the Fune completely fi 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signeture and title of certifier D26748 O Closed 1 (Item 23a) (Type, Print)
4419 FALLS RO BALTOMD 21211 30, Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

altimore, Maryland 21215-0020

P.O. Box 68760

Division of Vital Records.

State

Registrar

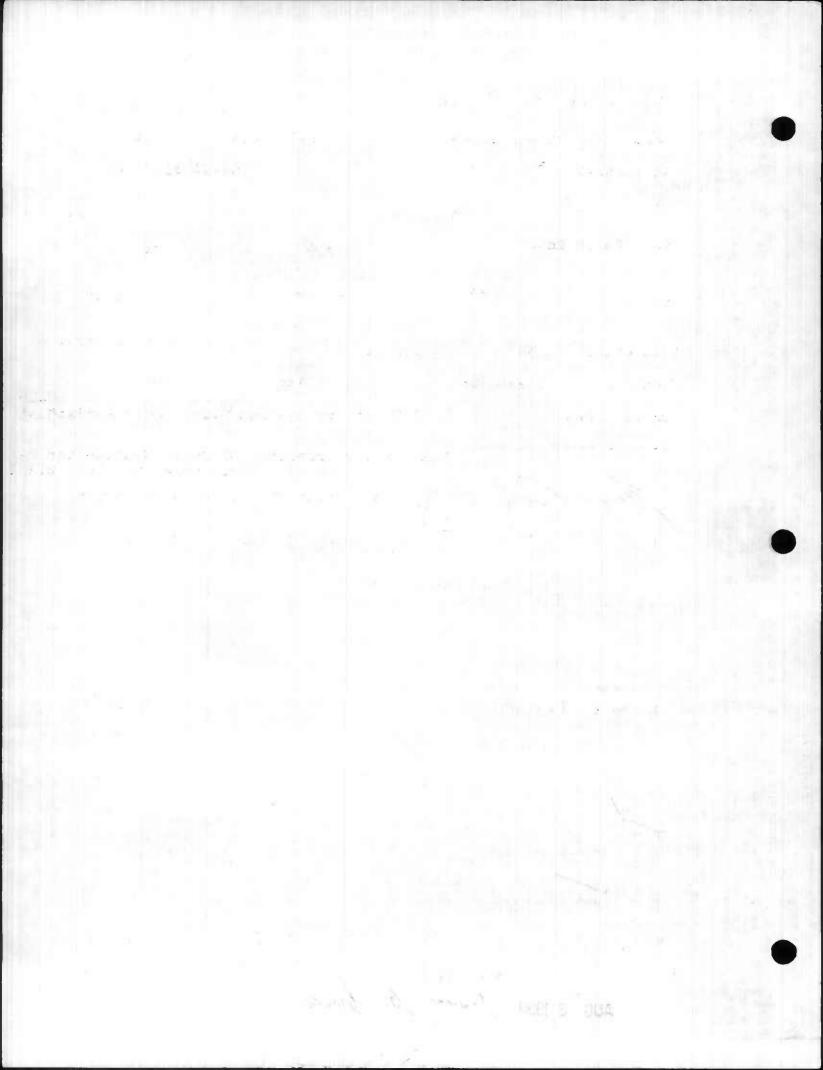
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31. Date tiled (Month, Day, Year)

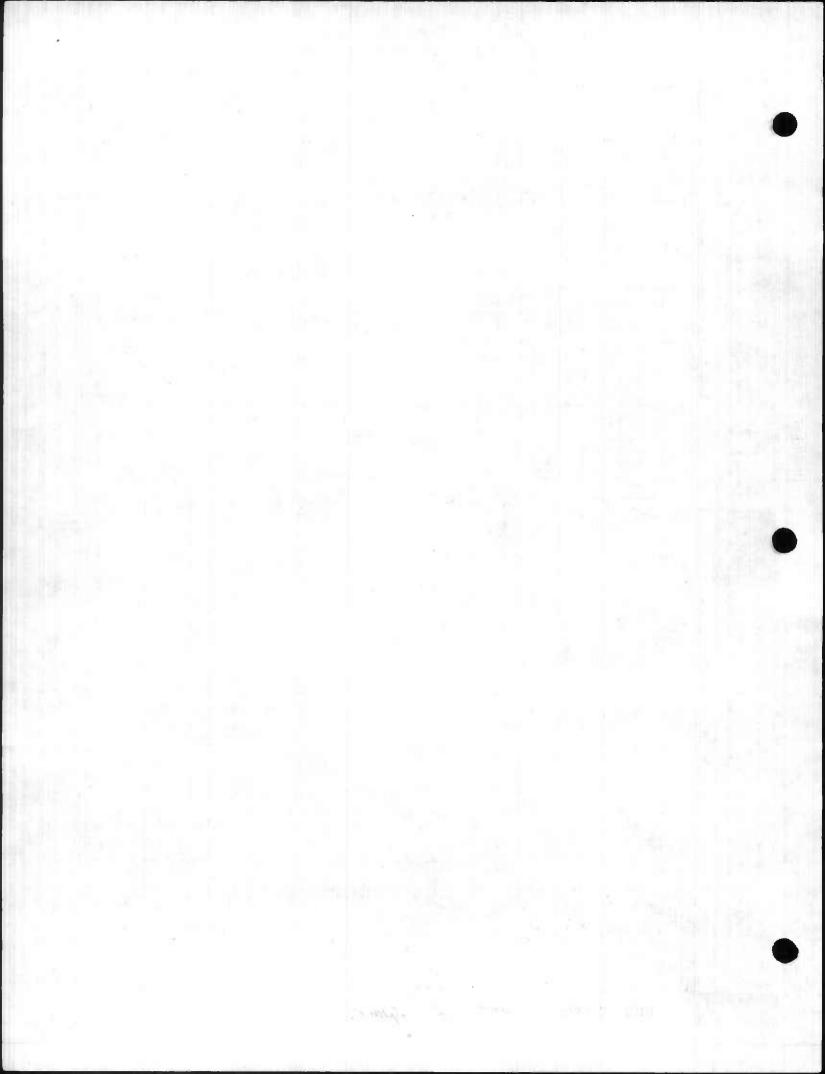
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MD

32. Registrar's Signature



			Plea	se Type Stat			d / Depa	artment	of H					ga	1e.	11	6	
Physiciar /Medica	ı.	1. Decedent's Name (First, Middle, Last)  Lucille Devreotes  2. Date of Death Month Day Yea July 31 199												व्वाव	3. Time 6			
Examine		Franklin S	square	Hospital	Cante	Y				Rose	dale		4c. County of Death Baltimore					
Funeral Director		5. Social Security Nur 088-05-9	299	6. Sex 1 □ M 25		82	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bi (Month, D 12/11,	71916	9. Birthplac Country New	Birthplace (State or Foreig Country) New York			
72 hours after death with the Maryland netural, or items 23s or 28s-f show deal Examiner must be notified at		Usuel Residence of D 10e. State MD	y.Town or Lo			10d. Inside				City Limits								
a 23a or 2 must be n		10e. Street and Number 8810 Walt	10f. Zip Code 21234					U.S.A.				•						
ours after death v rall, or items 234 Examiner must	5	1 ☐ Never Married 3 ☑ Widowed 4	S. 13. Was Decedent of Hispanic Origin? (Specify N If Yes, specify Cuban, Mexican, Puerto Rican  1 ☐ Yes 2 ☒ No Specify:					Rican, etc.)	Black, White, etc.  Specify: White									
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Timportant: if item 27 is marked other than "natural", any injury or other traumatic event, the Hed call East and injury.	and the second	(Specify	16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)  Homemaker					ng	16b. Ki	iness/Indus	stry							
Mental Hyg mrked other atic event,		17. Father's Name (F Charles		18. Mother's Neme (Fit					irst, Middle, Meiden Sumame) Montifusco									
f and 2 sho fealth and I m 27 is me ther traum		19a. Informent's Nam Peter De	1408	19b. Mailing Address (Street and Number or Rural Route No. 1408 Ellenglen Road Baltim						nore, Maryland 21286								
if. Pages internated H injury or of		20a. Method of Disposition 1 Buriai 2 Demoved from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, cremetory or other place) Ocean Memorial Park  20c. Location - City or Town, State 8/3/99 Toms River NJ.  21. Signeture of Funeral Secret Licensee  22. Name and Address of Facility  23. John C. Miller Inc.																
Depa (mpo (mpo (mpo (mpo (mpo (mpo (mpo (mpo	-	23a. Peat Enter the shock, or heart	Ala	mI	that caused	the death	64	15 Be	lai	r Road	l Bal	ltimore	e, Ma		nd 21	pproxime	ete .	
Physician /Medical Examiner		Immediate Cause (Fi disease or condition resulting in death)			rdioger										0	HOUL	Death	
be sit of				b. Acu	ate M	yocard		arction	<b>1</b>						6	Hou	rs	
	. 1	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):												4	ar			
at the death certificate be before the strending physici betached for use as the buphysician/Medical				d. At	herosc	leros	ÍS											
that the de ned by the sedesched		Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert Langustive Heart Failure									N.					of death? Unknow		
The law requires that the death certificate be as he as been signed by the attending physici, page 2 should be detached for use as the bu Completed by Physician/Medical													s an autop lormed?	osy	24b. Wers avails comp of de	able prior	to	
Physician: The law this certificate has al director, page 2	-	25. Was cese referre	d to medical			_				26. Place	of Death	1 Check only		XNo	101	/es 2[	□ No	
To the Hospital or Attending Physician: The law requires that the death cerwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use Medical Certification: To Be Completed by Physician Medical Certification: To Be Completed by Physician Medical Certification:	L	exeminer? 1 Yes 2 No. 27. Manner of Death 1 Natural 2 Accident	5 Pendin		1 ☐ Inpatie Dete of Inju (Month, Da		ER/Outpatien 28b. Time of Injury		Bc. Injur Wor	Other: 4 Nursing Home 5 Residence 6								
To the Hospital or Attending Pwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Medical Certification:		3 Suicide 4 Homicide	octory, office 28f. Location (Street and I City or Town, State)					d Number	r or Rural R	loute Nu	mber,							
the Hospit in 24 hour the Funera pletely fill		29a. Certifier (Check only one)	Certifyin Medical	g Physician: T caminer: On and	o the best of the basis of manner sta	examinat	wledge, death tion and/or inv	occurred a restigation,	it the tir in my o	ne, date and pinion, deat	place, a	and due to the ed at the time	, date and	place, an	nd due to th	e cause	(s)	
withi To the		29b. Signeture end	ll	lly	X	H.	D			3083 e unuper					(Month, Da	Ionth, Day, Year)		
		Dr. Gunta A	Wheele	r, Frank	In Squa	ire Ho	spital Co	ntar, 9	000	Franklin	Squai	re Drive,	Balt	imove,	MD 3	1123	7	
State Registrar		31. Date filed (Month, AUG	2 199	9 1	32. Registra	ars Signa	9. de	rocks	/									



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Des Earl Jane u 28 4a Facility Neme (If not institution, give street and number) 46. City, Town, or Location of Death 4c. County of Deeth Altimore If Under 24 Hra. 8: HOPKINS 7. Age (In yrs. last birthday) 73 Yrs. N/A PITAL hthday) If Under 1 Year JOHNS 8. Dete of Birth (Month, Day, Year 5. Social Security Number 6. Sex Birthplece (State or Foreign Country) Months Deys Min. Hours 214.22.9 71 1 ☐ M 2 💢 F 1926 MD Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7805 SEVEN MILE LANE 21208 U.S.A. Was Decedent of Hispanic Origin? (Specify Yea or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Raca - American Indian, 11. Meritel Stetus Bieck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 4 HOMEMAKER OWN HOME 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) JULIUS HOLLY WOLF DAVID NORA 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Addresa (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) EDWIN EARLY / HUSBAND 7805 SEVEN MILE LANE - BALTIMORE, MD 21208 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1. ☐ Buriai 2 Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) HILLTOP SERVICE CORP. 7/30/99 TOWSON, MD Tunerel Se 22. Name and Address of Fecility SOL LEVINSON & BROS., INC. ese, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e. List only one cau e on each line. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Deeth Immediate Cause (Final Septic shock disease or condition resulting in deeth) Vascular diseas Years phe Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Due to (or as e consequenca of) Due to (or es a consequence of) Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? End stage renal disease fram polycystic 1 ☐ Yea 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed? disease Coronary disease with pror myourdid infarction 1 Yes 2 No 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 27. Manner of Deeth 28b. Time of

Physician /Medical Examiner The law requires that the death certificate be executed

Department of Important: If any injury or

**Physician** 

/Medical

Examiner

**Funeral** 

Director

ns 23s or 28s-f shorman

the Medical Examiner

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Pages 1 and 2 should be nent of Health and Mental if item 27 is marked or other traumatic ev Director

Funeral

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Be Completed

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21215-0020

aitimore, Maryland

Box 68760,

P.O.

Division of Vital Records.

or Attanding Physician:

Examiner the burial-transit **Physician/Medical** USB 85 signed by the attending to be detached for use as Be Completed by this certificate funeral director, Certification: To To the Hospital or Attandit within 24 hours after death. To the Funeral Director: A filled in by

Netural

2 Accident

3 Suicide

29a Certifier

4 Homicide

(Check only one)

5 Pending investigation

28a. Dete of Injury (Month, Day Year) 6 Could not be determined

28e. Pleca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)

28c. Injury et Work? 1 Yes 2 No

28d. Describe how injury occurred

Location (Street and Number or Rural Route Number, City or Town, State) 28f.

29b. Signature and title of certifier MO

RES-000

29d. Date signed (Month, Day, Year)

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

JOHNS HOPKING HOSPITAL BALTIMORE, MD ROTHMAN , MO 31. Dete filed (Month, Day, Year)

🗷 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and placa, and due to the cause(s) end manner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) end menner stated.

29c. License number

State

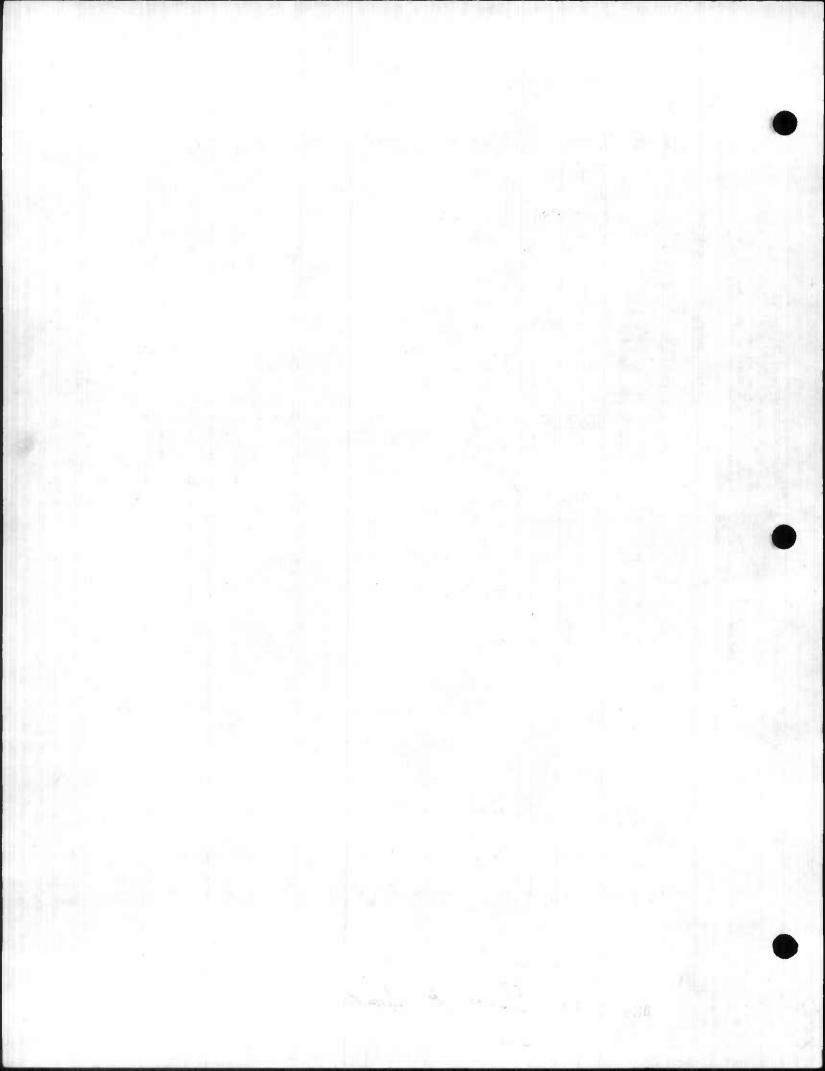
Medical

2 1999 AUG

32. Registrar's Signet

Registrar

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## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year 4:50 pm ED6E LOWALD 28,1999 4a Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Deeth 4c. County of Death The Johns Battimore If Under 24 Hrs. 8. Dete of Bit 00 Kinks Ta If Under 1 Yeer 8. Dete of Birth (Month, Day, Year) 04-07-34 9. Birthplace (State or Foreign Country) GA 6. Sex 7. Age (In yrs. last birthdey) Deys Months Hours MM 2□ F 65 260-50-7300 Yrs Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d, Inside City Limits MD NA X Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 111 N.Milton Avenue 21224 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien. Bleck, Whita, etc. 1 Never Married 2 Merried 1 ☐ Yes 2☐No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Yeer or Detes: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Disabled Unemployed 12th Grade NA 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Zigler Edge Rosalee Fambro 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Edge 102-24 184 Street Hollins, NY 11412 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremetion 3 ☐ Removal from Stete Calverton Nat'l Cem! 08-04-99 Riverhead NY 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Baltimore, Maryland 21202 21. Signeture of Funerei Service Licensee Demone WM.C.March FH 1101 E. North Avenue tomson 23a. Part1. Enter the disease, or corplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Deeth Immediete Cause (Finel Acrtic 10 hours disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 6001 24b. Were autopsy findings aveilable prior to completion of cause of death? 24e. Wes an eutopsy performed? Hyperfensor 10 Yes 2 No COPD 1 Yes 2 No 25. Wes case referred to medical examiner? 26. Piaca of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2NNo 1 Mipatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Neture 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 1 Contifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

Examiner or Attending Physician: The law requires that the death certificate be executed Box 68760. Division of Vital Records, P.O. signed by t has certificate this After after death.

I Director: Aft
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**Physician** 

/Medical

Examiner

**Funeral** 

Director

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**Physician** /Medical

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physician

Director

Funeral

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Completed

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Examiner

Completed by Physician/Medical

Be

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29e. Certifier (Check only one)

funeral

filled in

State Registrar

DHMH 16 Rev 6/95

31. Dete filed (Month, Day, Year) **AUG** 

29b. Signeture and title of cartifier

DISCORS MISHELL

32. Registrar's Signeture 1999

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ms,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

sultimore MD 21205

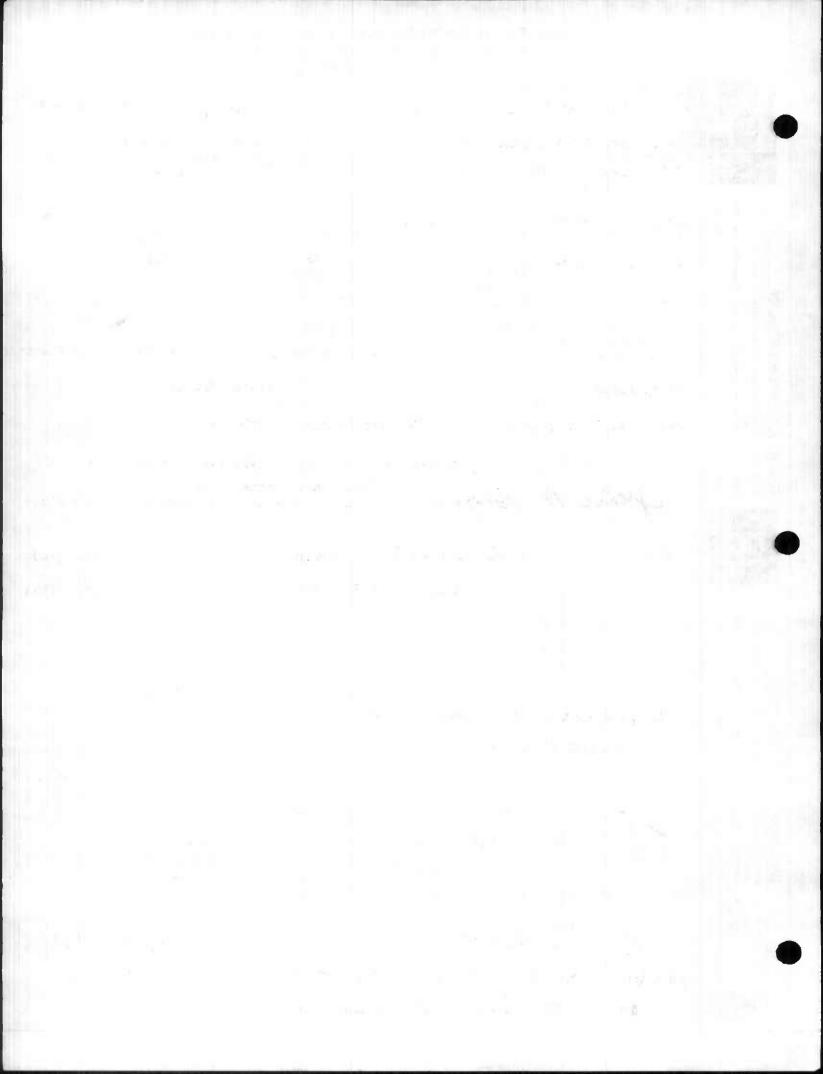
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 9

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	/Medi Exami		4a. Facility Name (If not institution, gi		101	mid		4b. City, To	wn, or Loc	ation of Death	4c. Count	of Death			
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₽	Funeral				e (In yrs. last bi	rthday) If Und	er 1 Year			8. Date of Birt	h			or Foreign	
	Director	П	215-07-3899	1⊠M 2□ F	86	Yrs. Month	Days	Hours	Min.	(Month, Day Feb 24,	y, Year)		place (State of	or r creight	
			Usual Residence of Decedent		00					ceb 24,	1913	Mary	land		
	de s		10a. State 10b. County		10c. City, Tov	m or Location						1	0d. inside Ci	ity Limits	
	Mery F B	0	Maryland Balti	more	Arb	utus							1 🗆 Yas	2/2 No	
	the 288	Director	10e. Street and Number			10g. Citizen of	What Coun	tn/2							
	with o							шуг							
	ath 23	rai	936 Regina Drive	140.00			212				U.S.				
	within 72 hours effer death with the Meryland ilene. Then "natural", or items 23s or 28s-f show the Medical Examiner must be notified as	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		13. Was Dec	edent of F ecity Cub	dispanic Orig an, Maxican	gin? (Spe , Puerto F	cify Yes or No- Rican, etc.)		ce - Amarica ck, White, e			
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Maryland	0 0 0		19e. Informant's Name/Relationship	(Type, Print)	198	. Mailing Addre	ss (Street	and Numbe	er or Rurai	Route Numbe	or, City or Town	, Stete, Zip	Code)		
	27 and		Joseph W. Flemin	g (Son)		936 Reg	ina D	rive	- Arl	butus,	Marylar	id 2	21227		
ore	of Healt Item 2		20a. Method of Disposition		20b. Place o	f Disposition (N	ame of	ce)		Date	20c. Location	- City or To	wn, State		
Ĕ	Page ent rt: ∓		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of the Cont			n Park		•	17	/31/99	Baltin	nore	Marul	and	
Baltimore,	permit. Pages 1 Department of H Important: If Itel any Injury or ott once,		21. Signature of Funeral Sarvica Lica		Loudo			ess of Facility		(31/3)	Darti	iore,	naryı	and	
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			Journ L	200	mon	4107	Vilke	ens Av	enue	- Balt	imore,	Maryl			
			23a. Party. Enter the disease, or con shark, or heart failure. List only	y one ceuse on each lin	ne.	not enter the m	ae or ayır	ng, such as	cardiac of	raspiratory ar	rast,		Approximat Interval Bet Onset and I	tween	
	Physician / Medicai		American Course (Treat												
	Examiner	16	disease or condition e. BRONCHO PNGUMONIA											reak	
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60,	cian cian														
68760,	sete l	Medical	that initiated events resulting in death) Last Due to (or as a consequence of):												
	ding p	M										į			
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P.0	thet the de ed by the deteched	Ph.	1-005000		1 Yes 2 No 3 Probably 4 Unkr										
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æ	0 - 0	Completed								1 🗆 Y	es 2 M No		Yes 20	Colo	
ta			25. Was case referred to medicat			-		00 01-	-1 D11			-	1105 202	140	
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	Physical distriction	: To	27. Menner of Death	1 ☐ Inpatie	ry 28b.	utpatient 3□ I Time of					lenca 6 Ott		0		
on	Attending Ph or death. ector: After th by the funeral	tlor	1 Naturet 5 ☐ Pending investigation	(Month Day	Year)	njury M	28c. Injur Wor	rk? Yes 2⊟≀				.00			
S	death.	ica	3 ☐ Suicide 6 ☐ Could not b	be Ope Diese of Inju				.00 2		of Location /6	Street and Num	har or Pura	I Pouto Alum	hor	
Division	or A offer offer in by	Certification:	4 Homicide determined	28e. Place of inju- building, etc	c. (Specify)	street, iacto	ry, onice			City or Ton		Jer or nura	7 House Mun	iber,	
_	ortal urs oral illed														
	To the Hospital or Attantwithin 24 hours efter deat To the Funeral Director: completely filled in by the	edicai	(Check only 2 Medical Exa	hysician: To the best of miner: On the bests of	examination er	e, death occurre d/or investigetion	d at the tir n, in my o	me, dete end pinion, deat	d place, e h occurre	nd due to the o d at the time, o	cause(s) and m dete end piece,	anner as st and due to	ated. the cause(s	s)	
	the the uple	Med	one)	and manner sta	ited.										
	7 ¥it		29b. Signature and title of certifier	10 85		2		e number	Ω		29d. Date signe	Month, l	Day, Year)	29	
			In 12, cook	3			D.	3046	Te		June	4715	, 10	4	
			30 Nema and/address of person who	completed cause of d	eeth (Item 23e)	(Type, Print)		÷ 102	011	>0000	TY.	Mn =	10: -		
			V	2055, Cl	cumbe	1 245/16	9	7 100	CIN	(01)	13) ; /	.M. 5	21042		
	Sta	te	31. Date filed (Month, Day, Year)	3. Registro	ar's Signature	1					•				
	Registr	ar	AUG 2 199	9 30	- 0	. 100	de	4							

Registrar



**Physician** 

/Medical

Examiner

**Funeral** 

Director

ehow.

Directo

Funeral

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Completed

21 Sign

7 is marked other than "natural", or itema 23a or 28a-f sho treumatic event, the Medical Examinar must be notified at

the Maryland

death

permit. Pages 1 and 2 should be filed within 72 hours effer a Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "natural" any injury or other treumatic average.

-Physician

/Medical

Examiner

certificate be executed physician and s the burial-trans Examiner

Physician/Medical

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Completed

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2

Certification:

Medical

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After

An 24 house the Funerel Director filled in by the

death.

Hospital

To the F within 2

director,

funeral

Division of Vital Records, P.O. ofter death Director:

DHMH 16 Rev 6/95

State Registrar

Yatnik 31. Date filed (Month, Day, Year) aug

29b. Signature and title of certifie

(Check only one)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

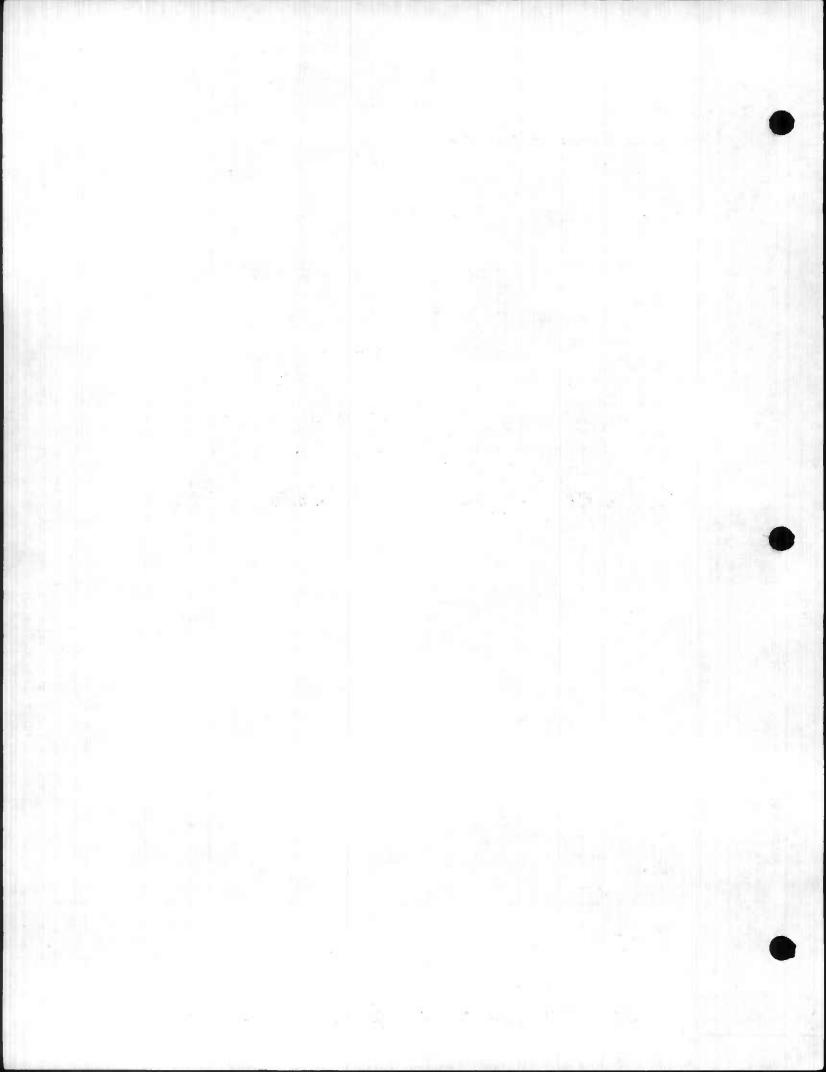
32. Registrar's Signature

Hospital of Baltimore

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

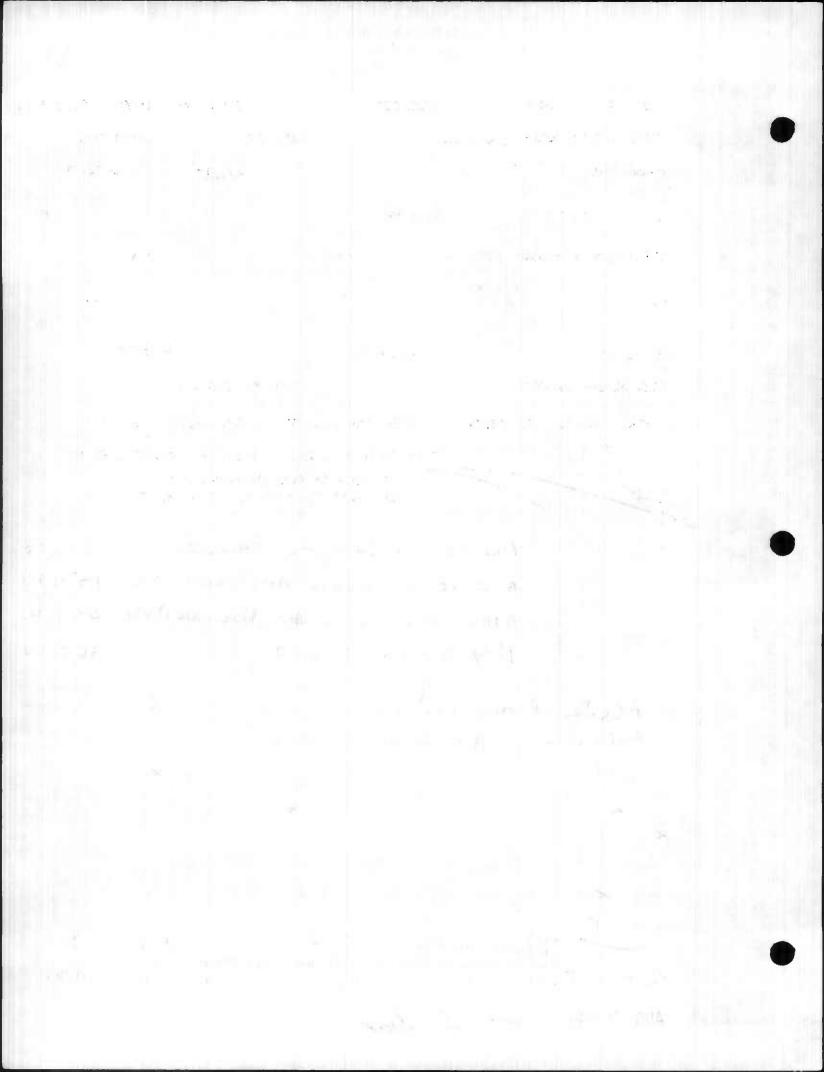


						Ce	rtificate	of l	Death		300	Reg. No.	0 4	4161	
п	Dhusisian	1. Decedent's Nem	1. Decedent's Neme (First, Middle, Last)								2. Date of De Month	3. Time of Death			
a.	Physician /Medical	HELE	N	ANNE	G	REGLO	[T				JULY	29 <sup>Day</sup>	1999	8:30 P.M	
	Examiner	4a Facility Name (	If not institution, g	give street end n	um <i>ber)</i>			4	b. City, Tow	n, or Loc	ation of Death	4c. Co	4c. County of Death		
A		GLEN M	EADOWS 1	NURSING	CENTER				GLEN	ARM			BALTIM	ORE	
	Funeral Director	5. Social Security N 216-66-5	5610	.Sex 1□M 2X F	7. Age (In yrs. le	st birthdey) Yrs.	If Under 1 Months	Deys .	If Under 2 Hours	Min.	8. Date of Bird (Month, De 4/4/10	h y, Year)	9. Bint Cor MAR	place (Stete or Foreign intry) YLAND	
	p ,	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location												104 1-14-04-11-1-	
	nylau how						10d. Inside City Limits								
	or 28a-f s or 28a-f s be northed	MD BALTIMORE GLEN ARM												1 □ Yes XX No	
	or 2														
	th w												JSA		
21215-0020	72 hours after deeth with the Maryland natural, or items 23a or 28a-f show deal Examiner must be northed at steed by Funeral Director		ied 2☐ Married	Armed F	<ol> <li>Was Decedent of Hispanic Original If Yes, specify Cuban, Mexicen,</li> <li>Yes 2√2 No Specify:</li> </ol>			Puerto Rican, etc.)			. Raca - American Indian, Black, White, etc. pecify: WHITE				
9	natural',		15. Decedent's	Educetion		16a. Dece	dent's Usuai	Occup	ation			16b. Kind			
15	5 5		city only highest		life. DO NOT use			done d	fu <i>ring</i> most ( )	of working	9				
212	Hygiene. ther than there. and, the Man	12TH GRA		College	College (1-4or 5+) HOMEMAKER							OWN	HOME		
	EISE O	17. Father's Name		st)		110111	( WILLIAM		18. Mother	's Name	(First, Middle,	Maiden Sui	mame)		
an	Mentel H Mentel H arked out artic ever	TA MHOT.	BERT FI	SCHER					ANN	E.K.	SETT.A	ND			
Maryland	12 should be filed h end Mentel Hygi h end Mentel Hygi 7 is merked other treumentc event, To Be Cc	JOHN ALBERT FISCHER  ANNE K. SEILAND  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zig													
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20	200	1 🗆 Burial 2	Decremation 3		State	metery, cre	netory or oth	her pled		7/				TITE MD	
tim		4 Donetion 5 Other (Specify) METRO CREMATORY, INC. 7/30/99 CATONSVIL											A2ATPP	E, MD	
Baltimore,	permit. Peg Department Important: I any Injury o	21. Signature of Funeral Service Licensee THE JOHNSON FUNERAL HOME, P.A.													
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		23a Part . Enter t shock, or hea	the disease, or co art failure. List or	prolications that ly one cause on	ceused the death.	Do not en	ter the mode	of dyln	g, such es c	ardiac or	respiratory a	rrest,		Approximate Interval Between	
	Physician /Medical Examiner	Immediate Cause disease or condition resulting in death)	(Final		NGE 97									3 weeks	
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68760,	iceta be is the bu	that initiated events resulting in death)	S		Due to (or	es e consec	uence of):								
9	ng plans as as Mec		24 T T	_ 14	YPB	RL	1713	DR	MIA	-				50 YEARY	
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	sed for	Part II. Other signif									23b. Did	tobacco usi	contribute	to the cause of death?	
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ta	certificate rector, per	25. Was cese refer	rred to medice!						26. Piace	of Death	(Check only o	one)			
>	F 5	examiner?	No.	Hospital:	Inpatient 2 E	R/Outpatie	nt 3 DO	A Oth	00 -		ne 5□Resi		Other (Spec	eifv)	
	Phy orthis eral o	27. Manner of Deat	th	28a. Dete	of Injury	28b. Time o	-	Bc. Injur			8d. Describe			,	
o	th. the fune	Natural 2 Accident	5 Pending Investigat		nth, Dey Year)	injury	м		k7 Yes 2∐N	lo					
Division	tal or Attending P is after deeth. al Director: After t ed in by the funer. Certification:	3 Suicide 4 Homicide	6 Could not determine	288. Plac	e of Injury - At hor ting, etc. (Specify)		reet, factory,						ral Route Number,		
	To the Hospital or A within 24 hours after To the Funeral Direct Completely filled in b Medical Certi	29a. Certifier (Check only one)	182 Certifying 2  Medical Ex	aminer; On the	e best of my know casts of examinetion	rledge, deat on end/or in	h occurred e vestigetion,	t the tin	ne, dete end pinion, deet	plece, a	nd due to the d at the time,	ceuse(s) an date and pla	d manner as ace, and due	stated. to the cause(s)	
	Me We	29b. Signature and	title of certifier	N			29c.		e number			29d. Date s	igned (Monti	n, Qey, Year)	
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		20.11	No system	17.4			2	Ann	0-11	10	04. 4	J MIA	15	/ ' ' ' /	
		30. Neme and addr	AST RA		meth) that to eat		Print) R	15	9 7	BAC	TIMO	RC	MDS	21228	
	State	31. Dete filed (Mon	th, Dev. Year)		Registrar's Signati				,	7 '					

State Registrar

AllG 2 1999

we & Sports



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death

**Physician** /Medical **Examiner** 

DELBERT L. HINKLE 4a Facility Name (If not Institution, give street and number)

1. Decedent's Nama (First, Middle, Last)

2. Deta of Death . 1999 AUGUST 1,

3. Tima of Death 9:10 P.M.

Director

Funeral

ğ

Completed

8

302 NURSERY RD.

4b. City, Town, or Location of Death LINTHICUM

4c. County of Death ANNE ARUNDEL

**Funeral** Director

or 28e-f show

Herrie 23a

8

hours after

Pages 1 and 2 should be filed within 72 in the page of Health and Mental Hygiene.

Hygiene.

Baltimore, Maryland 21215-0020

10b. County

10f. Zip Code

21090

Days

Months

If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JUNE 23, 1

9. Birthplece (State or Foreign 1932 WEST VIRGINIA

Usual Residence of Decedent

10a. Stata

MARYLAND ANNE ARUNDEL

1⊠M 2□ F

10c. City, Town or Location

Yrs

10d. Inside City Limits

1 ☐ Yas 2 No

5. Sociel Security Number

235-44-9421

LINTHICUM

7. Age (In yrs. last birthday)

67

10g. Citizen of What Country?

UNITED STATES

10e. Street and Number

302 NURSERY RD.

12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Give Year or Detes:

Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puarto Rican, atc.)

Hours

Black, White, atc.

11. Marital Stetus

1 Nevar Married 2 Married 3 ☐ Widowed 4 ☐ Divorced

1 Yes 2 No Specify

MACHINIST

Specify: WHITE

15. Decedent's Education (Specify only highast grade completed)

Collega (1-4or 5+)

16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

Elementary/Secondary (0-12) 8

18. Mothar's Name (First, Middle, Maiden Surnama)

REFINERY

17. Father's Neme (First, Middle, Last)

WILLIAM HINKLE

LUCY MEADOWS

19e. Informent's Name/Relationship (Type, Print)

JUNE L. HINKLE / WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 302 NURSERY RD., LINTHICUM, MARYLAND 21090

20a. Method of Disposition

1 Buriel 2 □ Cremation 3 □ Removal from State

20b. Plece of Disposition (Name of cametery, crematory or other place)

20c. Location - City or Town, State AUGUST

4 ☐ Ponation 5 ☐ Other (Specify)

MEADOWRIDGE MEM. PK.

4, 1999 ELKRIDGE, MARYLAND

21. Signa re of Funeral Sarvice Licensee

22. Name end Address of Fecility KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061

**Physician** /Medical Examiner

physician

the th

signed by i

peeu

has

certificate

at or Attanding Physician: Ts after death.

I Director: After this certificat of in by the funeral director, p

To the Hospital within 24 hours a To the Funeral Completely filled

filled in by

Physician/Medical

þ

Completed

Be

Certification: To

Medical

The law requires that the death certificate be executed

Box 68760.

P.O.

Records,

Division of Vital

Department of Health and Ma Important: if Health 27 is mark any injury or other traumation

Immediata Causa (Final disease or condition resulting in death)

Approximate Interval Between Onsat and Death

Sequentially list conditions, if any, laading to immediate cause. Enter Undarlying Cause (Diseasa or injury that initiated events resulting in death) Last

Dua to (or es a consequenca of):

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Due to (or as a consequence of)

Pert II. Other algniffcant conditions contributing to death but not resulting in the underlying causa given in Part I.

26. Place of Death (Check only one)

23b. Dfd tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

24b. Wara autopsy findings available prior to completion of cause of death?

1□ Yes 2⊠ No

1 ☐ Yes 2 ☐ No

25. Was case referred to medical 1 Yes 2 No

5 Panding investigation

Hospitel: 1 Inpatiant 28a. Data of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

29a, Certifier

6 Could not be determined 28e. Placa of Injury - At home, ferm, street, factory, office building, atc. (Specify)

1 Certifying Physician: To the best of my knowledga, death occurred at the time, data and place, and dua to tha causa(s) and mannar as stated. 2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, deeth occurred at the time, dete and pieca, and due to the cause(s) and menner stated.

281. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signatura and filte of pertifiar

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

29c. Licansa number D 58137

29d. Date signed (Month, Day, Year) AUGUST 2, 1999

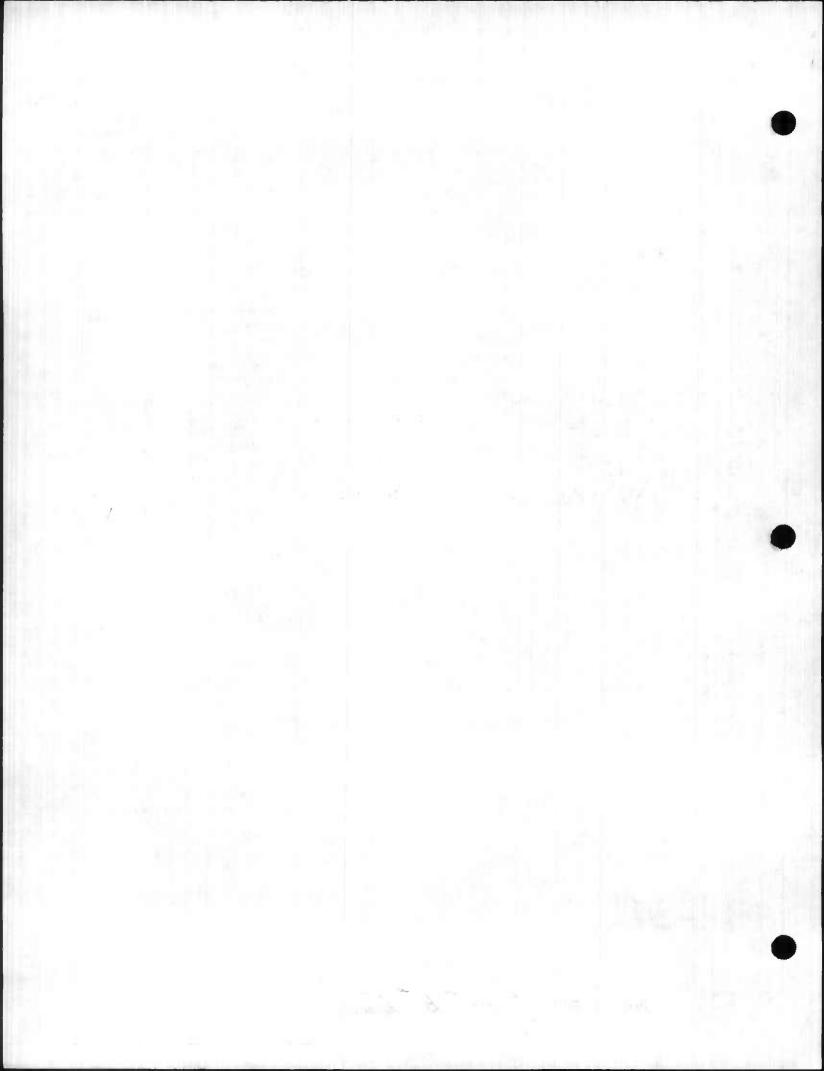
30. Name and addrass of person who completed causa of daals (fram 23e) (Type, Print)

RAMIREZ, M.D., PETER P. 7845 OAKWOOD RD., SUITE 201, GLEN BURNIE, MD 21061

State Registrar

31. Date filed (Month, Day Year) 999

32. Registrer's Signeture



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent'a Name (First, Middle, Last) 2. Date of Death . 1999 Month **Physician** July 31, 11:00am Clara Hensler /Medical 4a Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 640 Stamford Road Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 5, 1908 Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months 1 ☐ M 2 🖸 F Yrs. 212-05-6202 91 Director Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ahow other traumatic event, the Medical Examiner must be notified at MD Baltimore 1 ☑ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Нете 23а 640 Stamford Road 21229 U.S.A. death Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritel Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 Yes 2 No Specify: White Specify: p 3 Divorced 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry pernit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiana. Important: If flam 27 Ia marked other than any injury or other traumatic evant. the second of the Elementary/Secondary (0-12) College (1-4or 5+) Keypuncher Balto. Gas & Electric 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William A. Lehnert Jane Nice 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy L. Wolf (Niece) 2725 Ansley Drive, Finksburg, MD 21048 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Mother (Specify) Entombmen Lorraine Park Mausoleum 8/3/99 Woodlawn, Maryland 22. Name and Address of Facility Witzke Funeral Homes, Inc. 21. Signature of Funeral Service Licensee 1630 Edmondson Avenue, Catonsville, MD 21228 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Csuse (Finel disease or condition resulting in death) /Medical Stemosis 6 mouths Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Bud Due to (or as a consequence of): attending physician for use as the buriel P.O. Box 68760. that the death certificate be Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ate hes been signed by page 2 should be detac 1 Yes 2 No 3 Probably 4 W Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 ☐ Yes 2 H No 1 ☐ Yes 2 No this certificate Division of Vital Mospital or Attanding Physician:
 24 hours after death.
 Funeral Director: After this certifica director, Be 25. Was case rejerred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 - Residence 8 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To 1 Yes 2 -No funeral 28c. Injury at Work? 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 DNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the P within 2 To the F 29b. Signeture and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 215/2

State Registrar 30. Name III

31. Date filed (Month,

37747 WIL

DHMH 16 Rev 6/95

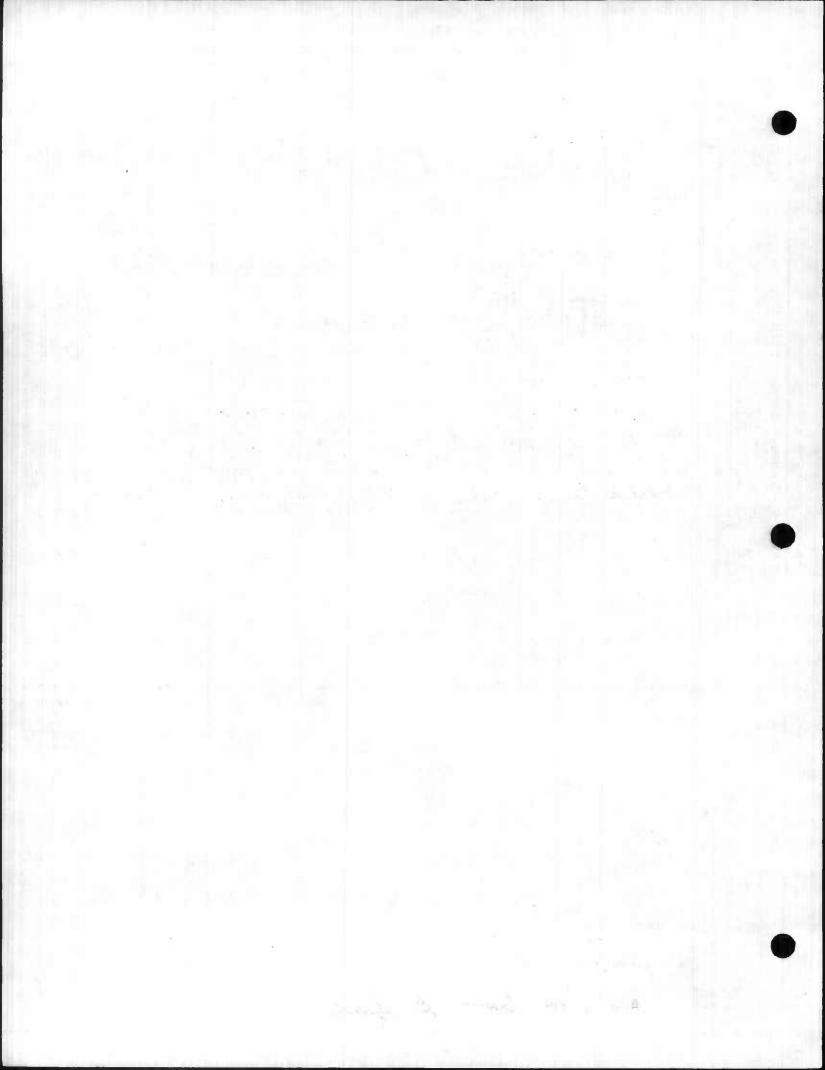
my

9 wilkens Ave Balt, Mil 2029

of person who completed cause of death (Item 23a) (Type, Print)

t. Cole

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24/24 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Deeth Day **Physician** Cornelia D. Hoffman AUGUST, 1:40 PM 1, 1999 /Medical 4s Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 4411 Adelle Terrace Baltimore If Under 1 Yeer | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 10 M 2 F Months 216-32-7088 Yrs. 21, 1904 Director MD Usual Residence of Decedent the Maryland pernit. Pages 1 and 2 should be filed within 72 hours effer deeth with the Marylan Department of Health and Mentel Hyglans. Important: if Itam 27 is marked other than "natural", or Nama 23a or 28a-f ahow with futury or other treumatic evant, the Medical Exemples must be notified at enter. 10a, Stata 10c. City. Town or Location. 10b. County 10d. Inside City Limits 1 Yes 2 No Director **Baltimore** 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 4411 Adelle Terrace 21229 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐XNo M Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indien. Black, White, etc. 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: White g 3 G-Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade comp 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) William C. Zies Elizabeth Richwien 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth H. Hoffman (Daughter) 4411 Adelle Terrace, Baltimore, Maryalnd 21229 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State Loudon Park Cemetery 8/6/99 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Witzke Funeral Homes, Inc. 1630 Edmondson Avenue, Catonsville, MD 21228 Stand Lemmer 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Finet disease or condition resulting in death) /Medical HYPERTENSIVE CARDIOVASCULAR SEVERAL Examiner Due to (or es e consequence of) DISEASE YEARS Examiner physician and the buriel-transit The lew requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): 68760 Physician/Medical Due to (or es a consequence of) for use as t Box ( P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown SACRAL AND SCAPULAR DECUBITUS PV Records, ULICERS . 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24e. Wes en autopsy parlormed? END STAGE RHEUMATOID ARTHRITIS. FIBRILLATION CHRONIC ATRIAL 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was case referred to medical axaminer? Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 1 Yes 2 No Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28c. Injury et Work? After 5 Pending investigation 1 Natural 24 hours after death.

Funeral Director: Aftivities in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 2 4 Homicide Hospital 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hos To the Fune completely fi 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signeture and title of certifier 29c. License number le-Rauf D-18362 .

State Registrar

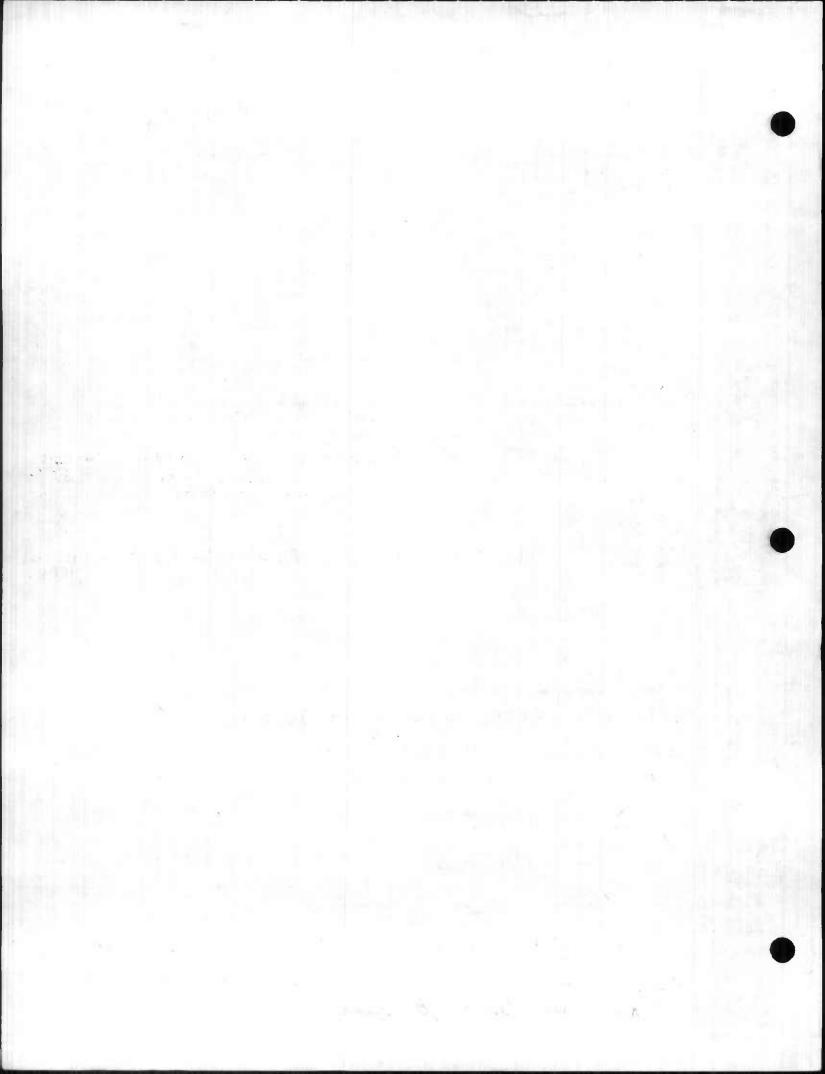
31. Date filed (Month, Day, Year) 2 1999 AUG

K. DANG

M.D., 3455, 32. Registrer's Signature

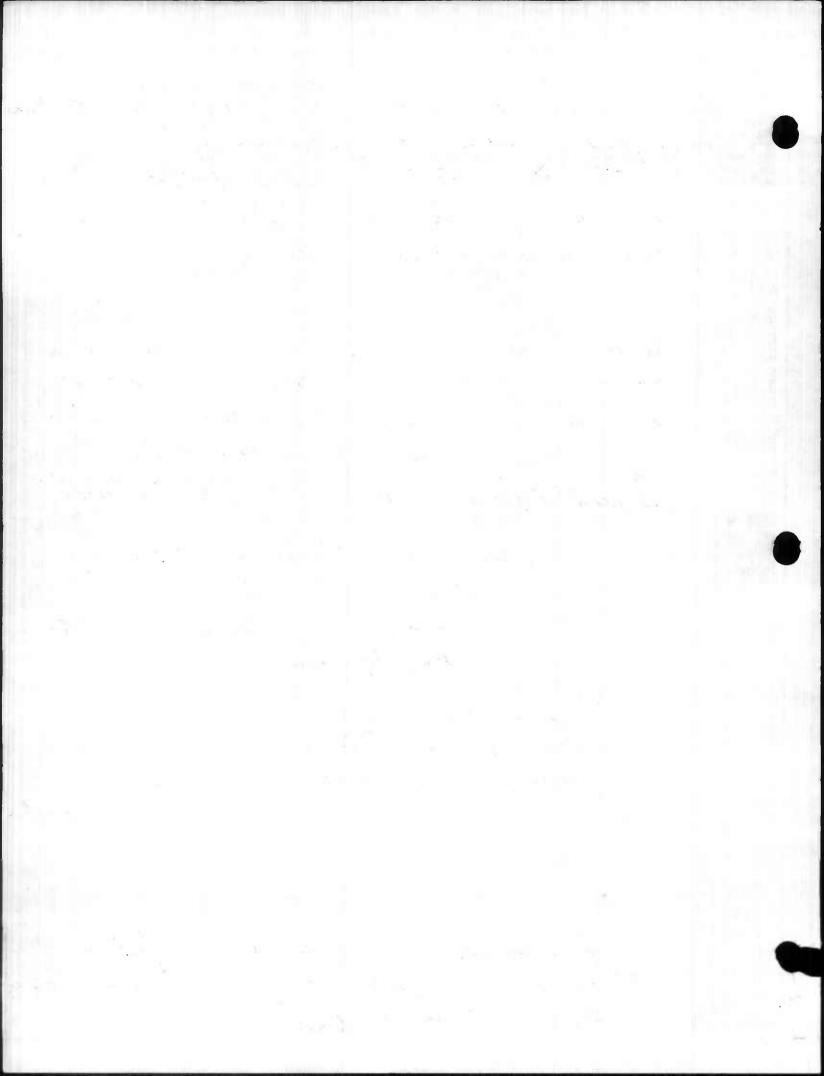
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WILKENS AVE, Suite 308. Balto. Md -21229



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deett 3. Time of Deeth **Physician** Month 5:23 HUTCHENSON OBERT 07 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street end number, 4c. County of Deeth **Examiner** NA Baltemore 7. Age (In yrs. last birthday) 7/mer Marylberd 5. Social Security Number If Unda Mortus Year If Under 24 Hrs. 8. Birthplece (State or Foreign Country) M D 1 M 2□ F 215-86-0017 Director Usuel Residence of Decedent deeth with the Meryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s4 show traumatic event, the Medical Examiner maint be notified at MYes 2 □ No Director MD Baltimore NA 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 904 W. Lexington Street Apt.#14 21223 USA Funeral 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes ※ SNo
If Yes, Give
Yeer or Detes: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours efter. Department of Heelth and Mentel Hygiene. If item 27 is marked other than "natural", or ite 1 ☐ Never Married 25 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) IIth Grade College (1-4or 5+) various trades Laborer 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herbert Mary Hutchinson Harvey 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 6 Ashlar Hill Court Baltimore, Maryland 21234 Mary L. Gee other 20b. Pleca of Disposition (Name of cemetery, cremetory or other p 20e. Method of Disposition 20c. Location - City or Town, Stete 1 XBuriat 2 ☐ Cremetion 3 ☐ Removel from Stete any injury or Kings Mem. PK. Cem. 07-29-99 Randallstown, MD 4 ☐ Donetion 5 ☐ Other (Specify) of Funeral Service 22. Name end Address of Fecility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear failure. List only one cause on each line. Approximete Intervai Between Onset and Death **Physician** /Medicai tmmediate Ceuse (Finel diseese or condition resulting in deeth) **Examiner** Examiner one he buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest pue Due to (or es e consequenca of) physician s the buriel P.O. Box 68760, 4IDS 8 Physician/Medical Due to (or as e consequence of): 88 ettending for ed by the e Pert It. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? ate has been signed by page 2 should be detec 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Records, þ 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Wes en eutopsy 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was case referred to medica examiner? 28. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Correct 2 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this funeral 27. Manner of Deeth 28e. Dete of injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After Attanding 5 Pending investigetion 1 Neturei death. 1 🗆 Yes 2 🗌 No or Attand efter death Director: 2 Accident in by the 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 Homicide Hospital of To the Hospital within 24 hours e Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end manner as steted.

2 Medicat Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) end menner stated. Medical 29a. Certifier 29b. Signeture end title of certiling 29c. License number 29d. Dete signed (Month, Day, Year) 0-46597 30. Name end address of person who completed cause of deeth (item 23e) (Type, Print) EDLA NB ESSBE 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State Registrar



DHMH 16 Ray 6/95

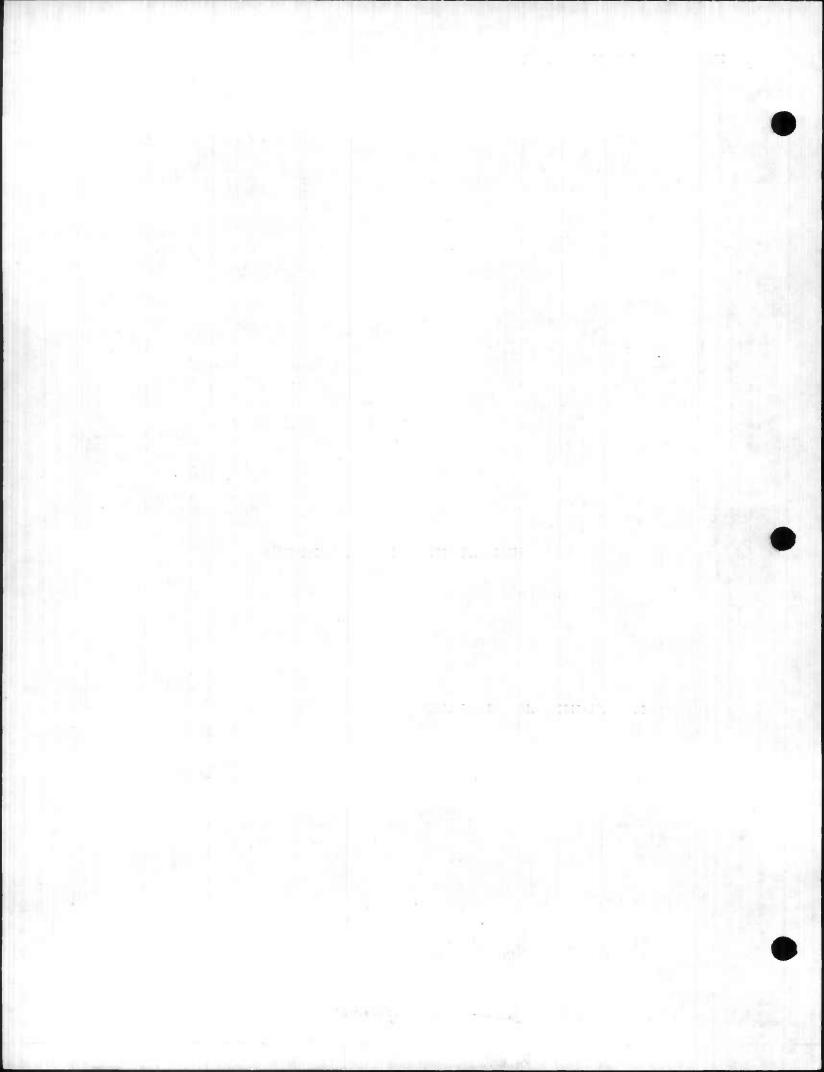
State Registrar 31. Dete filed (Month, Dey, Year)

AUG 0 2 1999

111 Penn Street, Baltimore, Maryland 21201

KORELLIM

32. Registrar's Signeture



Approximete Interval Between Onset end Deeth

1 ☐ Yes 2K No

29d. Dete signed (Month, Day, Year)

July 30,99

Pages 1 and 2 should be filed within 72 hours after of the filed within 72 hours after on of Health and Mental Hygiene.
nt: if Item 27 is marked other than "naturel", or item Saltimore, Maryland 21215-0020

> **Physician** /Medical Examiner

Department of important: If any Injury or

**Physician** 

Examiner

**Funeral** 

Director

ortant: if item 27 is marked other than "naturel", or items 23s or 28s-f show injury or other traumatic event, the Medical Examiner must be nother as

death with the Maryland

/Medical

10a State

Director

Funeral

2

Completed

MD

Examiner Physician/Medical p Completed Be Certification: To

ician and burial-trans the signed by the certificate this death. after death Director: Medicai

Division of Vital Records, Hospital or Attanding Physician: n 24 hours a To the I within 2 To the I

RUSSELL HOLT 19a. informent's Neme/Reletionship (Type, Print) LARRY JACKSON - SON 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVENUE BALTIMORE, MD 21224 23a. Part. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock of heart failure. List only one cause on each line. immediate Ceuse (Final Uro sepsis

Due to (or es a consequence of): disease or condition resulting in death) Renal Colcul. Sequentielly list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting In death) Lest Bone Marrow Failure Due to (or as e consequence of) 23b. Did tobacco usa contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evelleble prior to completion of cause of death? 24a. Was en eutopsy 1 TYAS 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 □ ER/Outpetient 3 □ DOA 28c. Injury at Work? 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homloide Leading Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as steled.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner steled. 29a. Certifier



29b. Signeture and title of certifier

31. Date filed (MAUGPay, 22ar) 1999

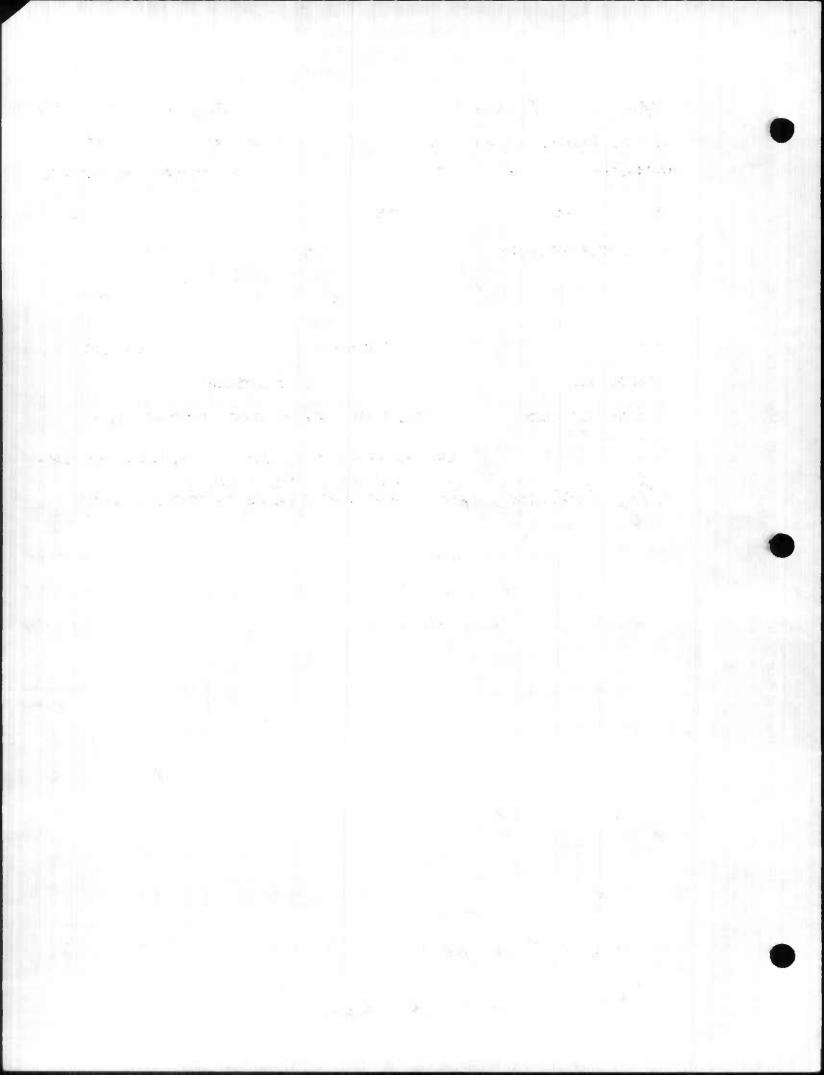
30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

State Registrar

William W. Roberts MD Johns Hepkins Hospital Boyview 32. Registrar's Signature

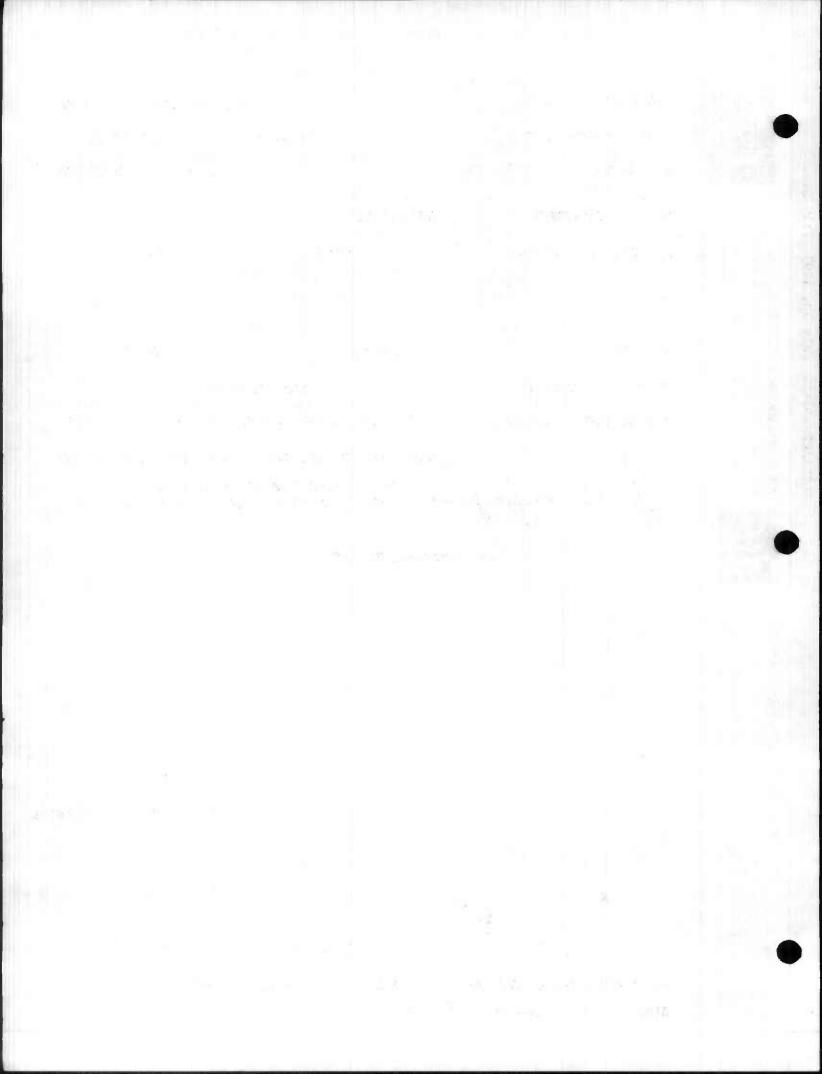
29c. License number

N7344



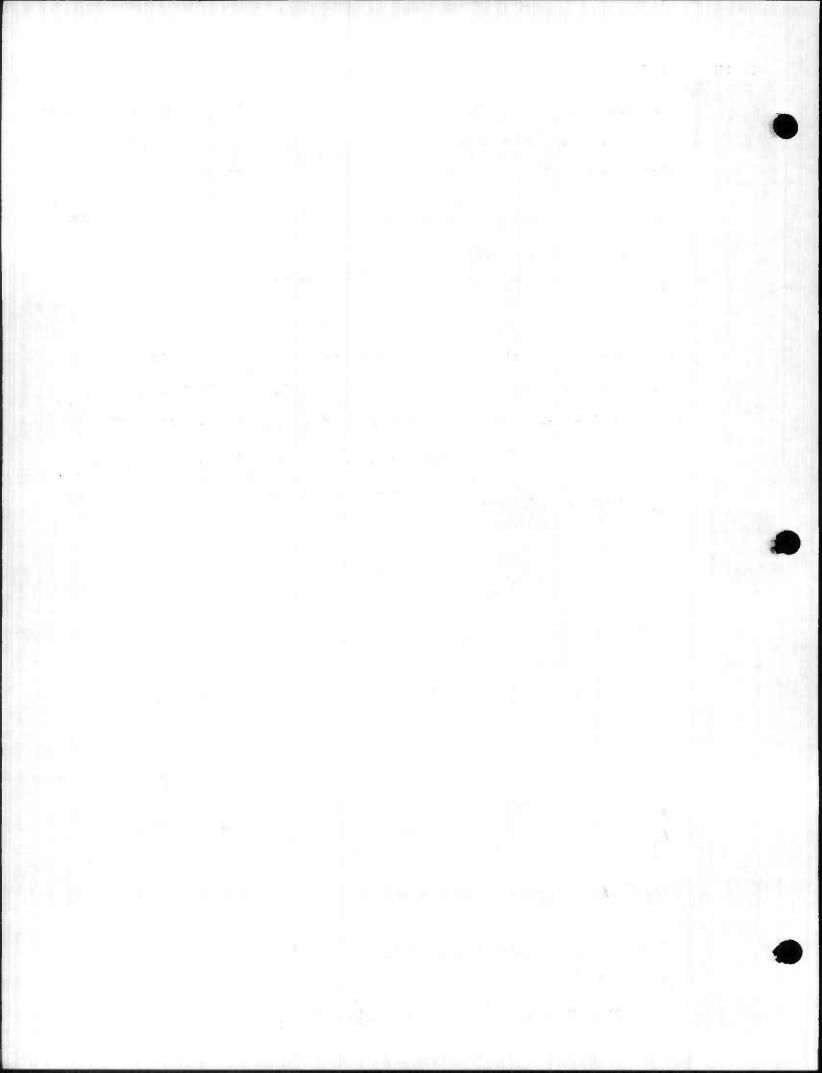
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State of Mandand / Department of LL	and the and Mantal Utrains 0 0

Physici		1. Decedent's Nem ELIZABE	ne (First, Middle, La TH E. J	st) ONES			tificate of		2. Dete of De Month JULY 30	Dev	Yeer	3. Time of Death
/Medic Examir			If not institution, giv	e street end number) SPICE				4b. City, Town, or L	ocation of Deat	h 4c. County	of Deeth	
Funeral Director		5. Sociel Security N 217-14-0			ge (In yrs. i 94	ast birthday) Yrs.	If Under 1 Year Months Deys	If Under 24 Hrs.	8. Date of Bir 7/11/0	th	9. Birtho	plece (Stete or Fore
a or 28a-f show Le notified at	or	Usuel Residence of 10a. State	f Decedent 10b. County BALTIMO	RE		, Town or Lo						0d. Inside City Lim
3a or 28a- at be notif	al Director	10e. Street end Nu 311 EAS	mber F RIDGELY	ROAD			10f. Zip Code 2109	93		10g. Citizen of USA	What Cour	
by Dy	by Funeral	11. Marital Status  1 Never Married 2 Married  3X3 Widowed 4 Divorced		12. Wes Decedent Ever in U,S. Armed Forces?  1			ecify Yes or No Rican, etc.)		ce - Americ ck, White,			
pene. r than "natu the Medical	Completed	Elementery/Seco		ducation ade completed) College (1-4or :	5+)	(Give i life. D		pation during most of work ed)	ing	16b. Kind ot B		dustry
l Hygier other th	Co	8th GRAI				HOM	EMAKER	Tao Markada Nasa	- 107 147-141-	OWN		
유명을	Be							18. Mother's Nam		, Meiden Sumen	ne)	
(Health and Menta tem 27 is marked other traumatic ev	70	CHARLES I. MCCLAIN  19e. Informent's Neme/Reletionship (Type, Print)  19b. Mailing Add						MARY E.		ner City or Town	State 7in	Code
		19e. Informent's Neme/Reletionship ( <i>Type, Print</i> ) 19b. Mailing Addres LOIS BOTELER DAUGHTER 8727 LAC							IMORE,		1234	
permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other it once.			,	Removel trom Stete	CE	lece of Dispos emetery, crem	sition (Neme of actory or other ple VALLEY M	ece)	Dete 8/2/99	20c. Location	City or To	own, State
ysician Medical aminer	Examiner	Immediete Ceuse ( disease or condition resulting in deeth)	(Finel	e. CEREBRO	DVASC	n. Do not ente	CCIDENT uence ot):	CH RAVEN B	LVD Tor respiretory a	OWSON,	MD 2	Approximete Intervel Betweek Onset and Deet
ettending physician and d for use as the burial-transit	edical	Sequentially list co if eny, leeding to in cause. Enter Unde Cause (Disease or that Initieted events resulting in deeth) I	Injury	d	Due to (or	es e consequ	ence of):					
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2 should	Completed									en eutopsy ormed?	ev	ere autopsy findin eileble prior to mpletion ot cause deeth?
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irector:	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined determined  28e. Plece of Injury - At home, term, street, factory, building, etc. (Specify)							28f. Location ( City or To	Street end Numb wn, Stete)	oer or Rura	al Route Number,
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within 24 hours at To the Funeral Di completely filled is		29b. Signeture end title of certifier 29c. Like					29c. Licen	29d. Date signed (M 7/30			d (Month	D 161



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

1	AMEND ITE	M:	Sta: #7 PER F.H. G774 8/2/99 WR.	e of Maryla	nd / Depa <i>Cer</i>	artment of I tificate of	lealth ar Death	nd Mental H	ygiene g	9 2	4129
	<b>D</b> I		1. Decedent's Name (First, Middla, Last)					2. Date of 0	Death	Vaca	3. Time of Death
	Physic /Medi		Michael N. Joh	nson				July	28,	Year 99	8:13am
	Exami		4e. Facility Name (If not institution, give street et	, or Location of De	Location of Death 4c. County of Death						
			1915 E. LaFayett			W11 - 1 - 1 - 1 - 1	Balti			IA	
	Funeral Director		5. Social Security Number 220-64-5593 6. Sex 1 M 20		l last birthdey) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of E (Month, I 09-0		9. Birthpl Count	ace (Stete or Foreign try) MD
	and w		Usual Residence of Decedent  10a. State 10b. County	10c, C	ity, Town or Lo	cation				10	Od. Inside City Limita
	the Maryland	io	MD NA		altimo						₩Wes 2[]No
	r 28s	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Coun	try?
	death with the Maryland ms 23a or 28a-f show r must be notified at	ie O	1915 E. LaFayette	Avenue		2121	13		USA		
Maryland 21215-0020	or its	by Funeral	Arm 1 □ If Ya	Decedent Ever in I ed Forces? Yes 2 12 No is, Give r or Dates:	Į.	Vas Decedent of I I Yes, specify Cub	Ilspanic Originan, Mexican, f	n? (Specify Yes or Puerto Rican, etc.)	Bla	ce - America ck, Whita, e	etc.
0-0	72 hours natural',		15. Decedent's Education	A = 41	16a. Deced	ent's Usual Occup	pation		16b. Kind of E	Susinass/Ind	ustry
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anc	ed de by	Be	17. Father's Name (First, Middle, Last)					Name (First, Midd		ne)	
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9			1 X Burial 2 ☐ Cremation 3 ☐ Removel 4 ☐ Donation 5 ☐ Other (Specify)			Mem . F		m. 08-0	2-99 Ar	hutu	g.MD
Baltimore,			21. Signeture of Funeral Service Licensee	)		. Name and Addra					and 21202
Ö		Barned & Oh	1.0.0	W	M.C. Ma	rch F	H 1101				
			23a. Part1. Entar the diseasa, or complications shock, or heert failure. List emy one cause	that caused the daa							Approximete Interval Batween
Box 68760,	sete be ohysicia the bur	Physician/Medicai Examiner	Immadiate Causa (Final disease or condition resulting in daath)  Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or Injury that initiated events resulting in death) Last		or as a consequence or a consequence or a consequen	uence of):	Š				
	death	sicia	Part II. Other significant conditions contributing	to daath but not re	sulting in the un	iderlying cause giv	ven in Part I.	23b. Di	d tobacco uae co	ontribute to	the cause of death?
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Records,	N S S	Completed						24a. Wa	s an autopsy formed?	eve	ra autopsy findings illable prior to npletion of causa laath?
<u>=</u>	The ate h	Con						10	Yes 2 No	10	Yes 2 No
Vital	ysician: The is certificate director, pag	Be	25. Was case refarred to medical axaminar?		-	Tau		Death (Check only	ona)		
of	5 00	ation: To	1 Name of Death 1 Natural 5 Pending 2 Accident Investigation Hospital:	1 ☐ Inpatiant 2 ☐ Data of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju		28d. Describ	sidance 6 🗆 Ot e how Injury occu		)
Division	D Pro	Certification:	3 Suicide 6 Could not be determined 28a.	Place of Injury - At houilding, etc. (Speci	nome, farm, stre	eet, factory, office		28f. Location City or T	(Street end Num own, Stete)	ber or Rure	Route Number,
	To the Hospital within 24 hours To the Funeral completely filled	edical (	29a. Certifier (Check only one) 1 Certifying Phyaician: T 2 Medical Examiner: On and	o tha best of my know the basis of examina manner stated.	owledge, death ation and/or Inv	occurred at the timestigation, in my o	ma, date and popinion, daath	place, and due to the occurred at the time	e cause(s) and m e, date and place,	anner as st	ated. the cause(s)
	To the To the Comp	N	29b. Signature and title of certifier	1 1		29c. Licens	se number	,	29d. Dete sign	ed (Month, L	Dey, Year)
			Noman 10	holas	n mi	DI	610		7-30	1-99	7
			30. Nama and address of parson who complated	causa of daath (Ita	m 23a) (Typa, I	Print)		1			
			JULAS HOPKINS H	uspital	B	altim	1 mb	21205			
	Sta Registr		31. Date filed (Month, Day, Vaar)  AUG 2 1999	32. Føgistrar's Sign	atura &	lone	41				



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State o

	Date of Death	3. Time of Dea
of Maryland / Department of Health and Men Certificate of Death	Reg. No. 99	24/36
f Maryland / Department of Health and Mei	ntal Hygiene	01100

Physician
/Medical
Examiner

Funeral Director

þ

Completed

Be

4a Facility Name (If not institution, giva street and number)

1. Decedeni's Neme (First, Middle, Last)

Month Day JULY 26, 1999 4b. City, Town, or Location of Death

3. Time of Death 0550 AM

**Funeral** Director

JOHNS HOPKINS HOSPITAL E.R. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 6. Sex-1 M M 2 ☐ F

BALTIMORE

4c. County of Death

219-98-8444 Uaual Rasidence of Decedant 10a. State

Months Yrs.

If Under 24 Hrs. Hours Min. Days

Birthpleca (Stata or Foraign Country)

6 234

ò

the Medical

other

들 Department of important: If any injury or

Physician

The law requires that the death certificate be executed

Box 68760,

P.O.

Division of Vital Records,

/Medical Examiner

138

Completed by

Medical Certification: To Be

After this funeral

or Attending

ne Hospital or Attendi n 24 hours after death. ne Funeral Director: /

within 2

death.

then

Hygiene.

Pages 1 and 2 should be filed nent of Health and Mental Hygi ant: If Item 27 is marked other

the Maryland

filed within 72 hours after

21215-0020

Baltimore, Maryland

10b. County

10c. City, Town or Location

10f. Zip Code

10d. Inside City Limits 1. Yas 2 No

10e. Street and Number

11. Marijel Status 1 Never Married 2 Married

3 ☐ Widowed 4 ☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forcas?

1 ☐ Yes 2 M No If Yes, Giva Yaar or Detas:

 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuban, Mexican, Puerto Rican, atc.) 1 ☐ Yes 2 DANO

FRICAN AMERICAN

15. Decedent's Education (Specify only highast grada completed)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Businass/Industry

10g. Citizen of What Country?

Elemantary/Secondary (0-12)

College (1-4or 5+)

STUDENT

SCHOOL

17. Father'a Nama (First, Middla, Last)

JONES

18. Mother's Name (First, Middle, Maiden Sumama)

AWRENCE

19a. Informant's Name/Ralationship (Type, Print)

Grandauetta)

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 5424

BALTIMORE, MD Data 20c. Location - City or Town, State

20a. Mathod of Disposition

1 ABurial 2 □ Cramation 3 □ Removal from Stata 4 Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cematery, crematory or other)

21. Signature of Funaral Sarvice Licensee

22. Name and Address of Fac Albf1t 6.38 N. G 23a. Part 1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

MD 212/7

Immediata Causa (Final disease or condition resulting in death)

Dua to (or aa a consequence of):

Approximata interval Between Onsat end Death

Examiner Sequentially list conditions, it any, laading to immediate causa. Entar Undarlying Cause (Disease or Injury that initiated events rasulting in death) Last Physician/Medical

Dua to (or as a consequence of):

Dua to (or as a consequence of):

26. Place of Death (Check only ona)

23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown

24a. Wes en autopsy performed?

1 Yes

24b. Wara autopsy findings aveilable prior to completion of cause of death?

1 Yes 2 No

25. Was case rafarred to medical examinar? 1 Yas 2 No

5 Pending invastigation

6 Could not be datamined

27. Mannar of Death

2 Accidant

3 Suicida 4 Homicida

1 Natural

Hospitel: 1 Inpatient 28a. Data of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA 28b. Tima of injury 0516

28c. Injury at Work? 1 Yes 2 7 No

Other: 4 Nursing Home 5 Rasidence 8 Other (Specify) 28d. Describe how injury occurred Subject

2 No

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Certifier (Check only one)

28a Place of hjury - At homa, ferm, street, factory, office building, etc. (Specify) Street: Found - Parking of of 200 South Spring Ct.; Balting 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

\*\*Medical Examiner: On the best of examinetion and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i.

29c. License number

O.C.M.E

29d. Data signed (Month, Day, Year) JULY 27, 1999

30. Name and address of person who compresed cause of death (Item 23a) (Type, Print)

OSCA (Destance 111 Penn Street, Baltimore, Maryland 21201

31. Date Liled (Month, Dey, War) 2 1999 AUG

29b. Signetura end title of certifie

32. Registrar's Signature

State Registrar

completely

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month JORDAN 1999 0930 AM GEORGIA JULY 29 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOPKINS HOSPITAL BALTIMORE n/a If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) if Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□ M 2₩ F Months Days Yrs. 65 501-30-1413 March 30,1934 Iowa Usuei Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. fnside City Limits 1 ☐ Yes 2 No Maryland Baltimore Timonium 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 2226 Wonderview Road 21093 USA 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes, 2 No if Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian. Black, White, efc. 1 ☐ Never Married 2 ☑ Married 1 Yes 2 No Specify: 8 Widowed 4 Divorcad White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 04 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George Buchanan Mary Ellen Iverson 19a. fnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry Jordan/Husband 2226 Wonderview Road, Timonium, MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other placa) 20c. Location - City or Town, State 20a. Method of Disposition Dete 1 

Buriai 2 □ Cremation 3 □ Removal from State Decration 5 Other (Specify) Garrison Forest Cemetery 8/2/99 Garrison, Maryland Funeral Service Licenses 21. Signale 22. Name and Address of Facility W. Clary Lemmon Funeral Home Bryan 10 W. Padonia Road, Timonium, MD 21093 23a. Part 1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock, or heer failure. List only one cause on part line. Approximate Intervei Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) NON HODGKINS LYMPHOMA YEAR Due to (or as a consequence of): 2 WEEKS PLEURAL EFFUSION DUE TO LYMPHOMA Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as e consequence of): Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco usa contribute to the cause of death? 1 - Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings eveilable prior to 24a. Wes an autopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitai: 1 X Inpatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 X Natural 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piaca of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide

physician and the buriel-transit certificate be executed P.O. Box 68760. 98 USB signed t Records, page 2 has certificete Division of Vital director, this funeral After

**Physician** 

/Medical

Examiner

Director

Funeral

by

Completed

Be

**Funeral** 

Director

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Marylen nent of Health end Mentel Hyglene.
Int: If Itam 27 Is marked other than "natural", or items 23s or 28s-f show ary or other traumatic event, the Medical Examines must be notified as

permit. Page Department of Important: If any Injury or once.

**Physician** 

/Medical

**Examiner** 

Examiner Physician/Medical p Completed 일 Certification:

29a. Certifier

(Check only one)

29b. Signature and title of certifier

ATCHION M.S

death. s after death Hospital

24 hours edicai within 2 To the

> State Registrar

M.D AKHTAR, 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) end menner es stated

SYED SAAD AKHTARMD D 0043489

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated.

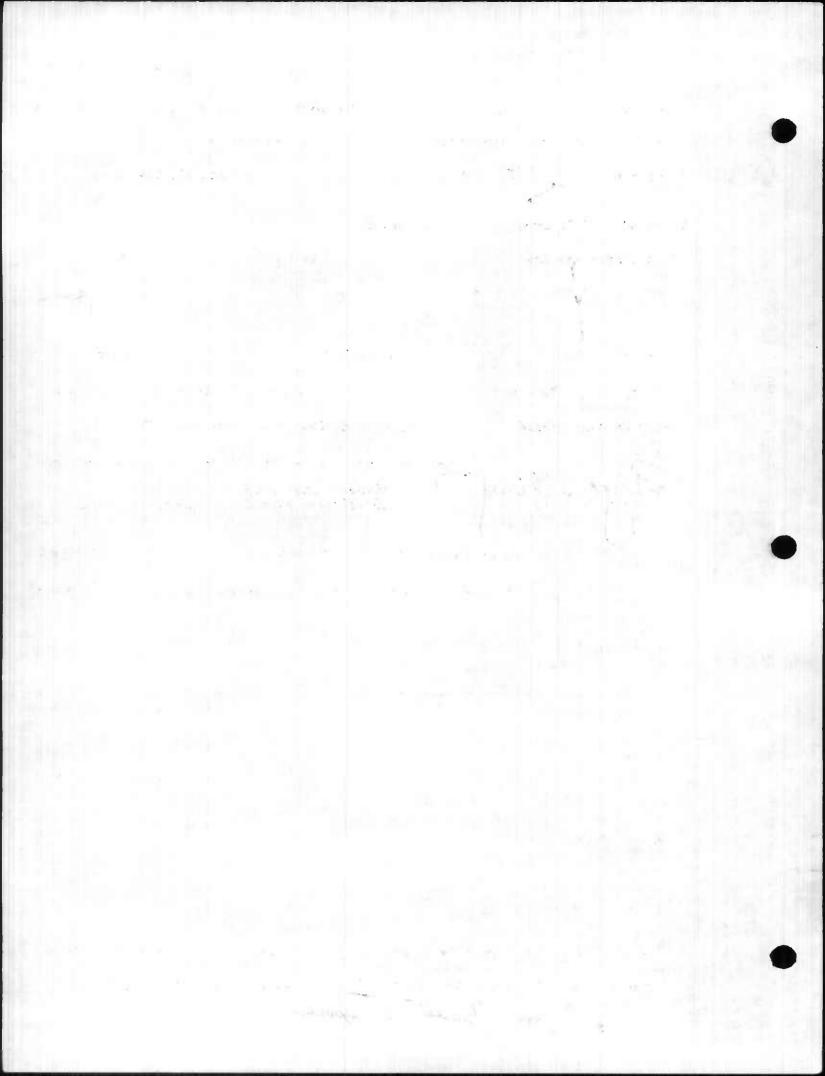
29d. Date signed (Month, Day, Year)

JULY

1999

21287

600 North Wolfe St., Baltimore, MD



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Q AMENDED ITEM #5 PER FH G774 8/2/99 AH Certificate of Death 3. Time of Death dent's Name (First, Middle, Last) 2. Date of Death Month 10 **Physician** 1999 July /Medical City, Town, or Location of Death 4c. County of Death Name (If not institution, giva street and number) Examiner Baltimore Social Security Number 9467 6. Sax 9. Birthplace (State or Foreign Country) and If Undar 24 Hrs. 8. Date of Birth If Undar 1 Yaar 7. Age (In yrs. last birthday) **Funeral** Days 1 M 200 F Months Hours **Director** Usual Rasidence of Decedent with the Meryland 10b. County 10a Stata 10c. City, Town or Location 10d. Inside City Limits mast be notified at 1 1 Yes 2 No ChARLOT Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? SF di Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cyban, Mexican, Puerto Rican, etc.) Home 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No 14. Race - American Indian, Black, White, etc. traumatic event, the Medical Examiner 1 Nevar Marriad 2 Married Specify: Black 6 1 Yes 2 No Baltimore, Maryland 21215-0020 Specify by 3 ☐ Widowed 4 ☐ Divorced "naturef" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use refired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 is marked other than ' College (1-4or 5+) Elementary/Secondary (0-12) OFFICE Investigator 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Margare Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City of Town, State, Zip Code) Balto. 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Comation 3 Removal from State injury or Department of important: If Memorial Other (Specify) 4 Donation 3 22. Name and Address of Facility

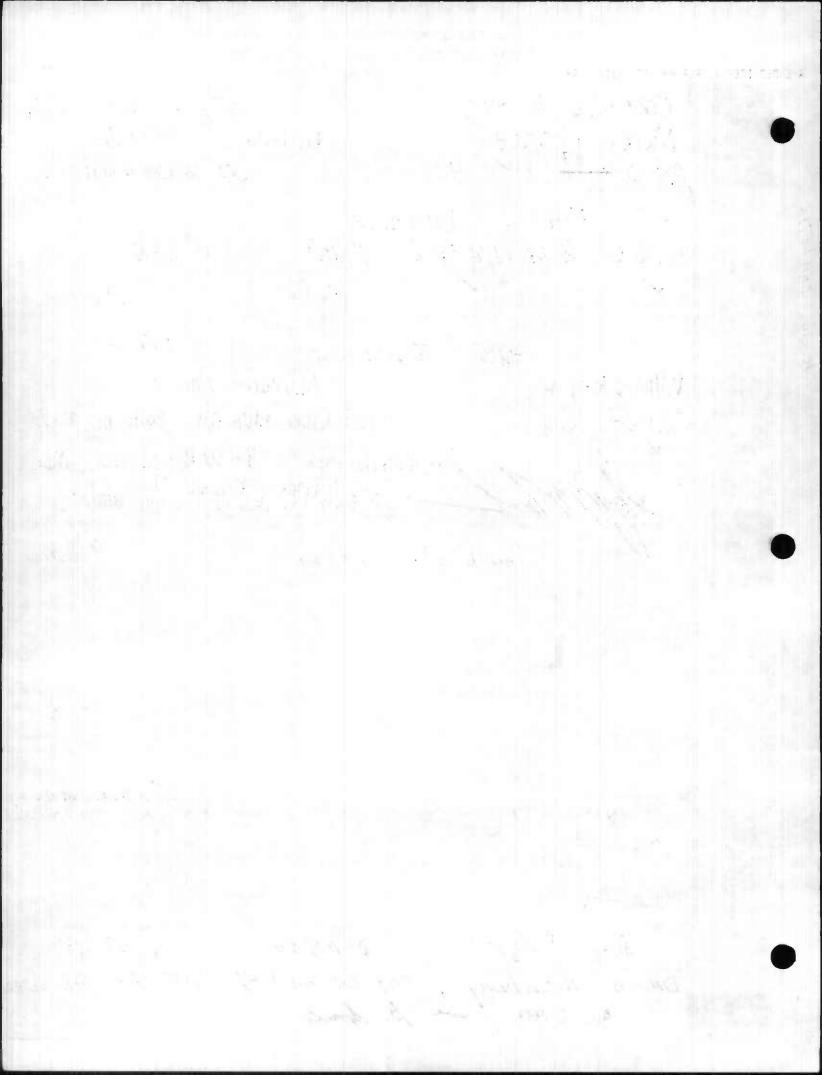
ATO Fredhillon any of complications that causad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death **Physician** · PANCREATIC Immediate Cause (Finel disaese or condition resulting in death) months /Medical Examiner Examiner physician and s the buriel-trans Sequentially list conditions, if any, leading to Immadiate causa. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760 Physician/Medical Dua to (or as a consequence of) 80 USB Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to complation of cause of death? 24a. Was an autopsy Completed has 2 No 1 ☐ Yes 2 ☐ No 25. Was casa referred to medical examiner? 26. Place of Death (Check only one STE ) A MARIS AT MERCY Be Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSpicE Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpetient 3□ DOA 28a. Date of Injury (Month, Dey Year) funerai 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending after death. 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 ☐ Sulcida 28f. Location (Streat and Number or Rural Routa Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral E Hospital Lactifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai completely (Check only one) 29c. Licanse number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartifler 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St PAUL PI, BAHIMORE, MD 21202 32. Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

DHMH 16 Rev 6/95

AUG

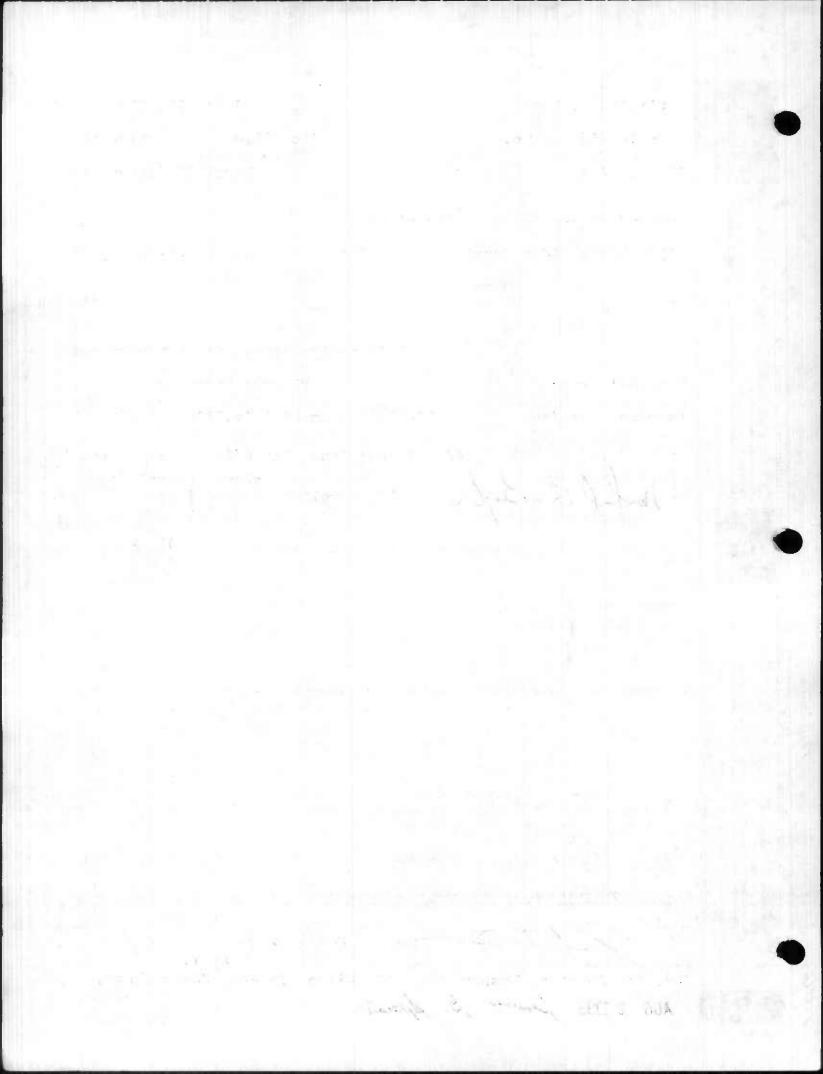


# Please Type or Print In Black Indelible Ink. Assure All Copies Are begible, | 33

	1 Decedent's N	ame (First, Middle,	l ast)		ertificate o	Dealli	2. Date of De	Reg. No.	T	3. Time of Death
in ail	EVE	V-1	10 O T 13 T O	Evelyn Vir	ginia King		Month 6	Day	Year 99	09:27
ner	48 Facility Name (if not institution, give street and number)									
	5. Social Securit 217-18-	ly Number 6		Age (In yrs. last birthda 80 Yrs		ar If Under 24 H	rs. 8. Dete of Bi	rth	9. Birthpla	ace (State or Foreig
	Usual Residence	e of Decedent 10b. County		10c. City, Town or Location					10	Od. Inside City Limit
	Maryland	d Washing	gton	Hagerst	own				tXXYes 2 □ No	
	10e. Street and				10f. Zip Code			10g. Citizen of V	Vhat Count	try?
		uther Driv		et Francis II C	2 Mar Decedent of	21740	(Cassity Vacas N	U.S.A	e - American Indien,	
	1000	larried 2 Married d 4 Divorced	12. Was Decede Armed Force 1 Tes 21 If Yes, Give Year or Date	s? ☑ No	3. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☑ N	iben, Mexican, Pu	erto Rican, etc.)	Bied	k, White, e	etc.
		15. Decedent's pecify only highest of	grade completed)	(G	cedent's Usuel Occ ve kind of work don DO NOT use reti	e during most of w	vorking	16b. Kind of Bu	rsiness/Indi	ustry
	0-1	econdary (0-12) 2	College (1-4	or 5+)	ales			retail		
	17. Father's Nar	ne (First, Middle, La				18. Mother's N	leme (First, Middle			
	10e Informact's	Clarence Russell Summers  Julia Ellen Groff  19a. Informant's Name/Relationship (Type, Print)  19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Sta								Code)
			e/son-In-I		Laidig E					
Department of He Important: If Nem eny Injury or othe page.	20a. Method of	•	DD	20b. Place of Dis	sposition (Name of remetory or other p		Dete	20c. Location -		
		on 5 Other (Spe	☐Removel from Sta cify)		ven Cemet	ery	July 14,		own,	Maryland
	21. Signature of	Funeral Service Lic	censee		22. Name end Add		Minnich			1 1 01
	22a Part Fre	2000	111/1U	sed the death. Do not					, Mar	ryland 21
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	resulting in deal	th)	b. Comp	Due to (or as a conductor for a conductor for a condu	rgan Far sequence of): f Myoca sequence of):	ilure rdial is	rfarction	1		3 days
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene 9 2 4 1 3 4

					Certific	ate of	Death		Reg. No.				
Physici	ian	1. Decedent's Name (First, Middle, Las	•					2. Date of Dea		Veer	3. Time	of Death	
/Medic		Lillian H. Le	ese					June	12,	1999	6	AM.	
Examir		4a. Fecility Neme (If not institution, give					4b. City, Town, or		4c. County	of Death			
		Maple Ridge I	Home.				Rockvi	11e	Mor	ntgom	nery		
Funeral Director		5. Social Security Number 6. Set 5 7 9 - 0 9 - 14 3 4	7. Age □M 2⊠F	(In yrs. last bir	Yrs. If Un Mont	der 1 Year hs Days		8. Date of Birth (Month, De) March	20, 13	9. Birthpli Count Ne W	Yor	or Fore	
death with the Maryland ime 23a or 28a-f show if must be nothing at		Usual Residenca of Decadent  10a. State 10b. County		10c. City, Tow	n or Location					10	d. Inside (	City Llmi	
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# 72 F 72	Jr e	10e. Street end Number			10f.	Zip Code			10g. Citizen of \	Whet Count	ry?		
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or the	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent En Armed Forces?  1  Yes 2 No. If Yes, Give Year or Dates:				Hispanic Origin? (S ban, Mexicen, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Rec Bled Specify	e - America ck, White, e			
"natural",	ted	15. Decedent's Edu	cation	16e.	Decedent's U	sual Occu	pation		16b. Kind of Bu	usiness/Indu	ustry		
filed within 7 Hygiene. nther than "n	Completed	(Specify only highest gred Elementery/Secondary (0-12)	College (1-4or 5+	)			pation during most of wor ed) ive Ass		US Go	overn	men	t	
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id be entel ked c	0 0	Emmanuel Hertz		Blanche				he Rose	enthal	-,			
permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: if Item 27 is marked other t eny Injury or other traumatic event, in	-	a. Informant's Name/Reletionship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 16012 Chester Mill Tr.Silver Sp								State, Zip (	Code) 21	B90	
		20a. Method of Disposition  X□ Burial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)		20b. Place of	Disposition (I	Verne of or other ple		Date	20c. Location -	City or Tow	vn, State		
	21. Signature of Fundral Service Licens	2-Byle 254 Carroll St.NW Washing											
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/Medicai		Immediate Cause (Final disease or condition resulting in death)  Arthersclerotic Heart Disease  Due to (or as e consequence of):								į	Year	re	
Examiner											1 Ca	13	
	ē		U	ue to (or as e o	consequence	or):							
exacuted n and iel-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events	D	ue to (or es a c	consequence	of):							
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00	To	1 ☐ Yes 2√ No	fospital: 1   Inpatient	2 ER/Out	tpatient 3	DOA Ott	her: 4 Nursing H	ome 5 Resid	enca 6 🖾 Oth	er (Specify)	Gro	up	
Attending Physical Attention of the funeral by the funeral		27. Menner of Death  1 ☑ Naturel 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of Injury (Month, Dey			28c. Inju Wo		28d. Describe h				ome	
to the Respital or Attending Phywithin 24 hours after death.  To the Funerel Director: After this completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	3 Suicide 6 Could not be 28e Place of Injury - At home farm street factory office 28f Location (Street and Number or Purel River Injury - At home farm street factory office								Route Nur	n <i>ber</i> ,	
vithin 24 hours of the funerel I completely filled	edical	29a. Certifier (Check only one) 1∑ Certifying Physical Check only 2 Medical Examination (Check only one)	ilcian: To the best of a ner: On the basis of ea and manner state	xamination and	death occurre Vor Investigati	ed et the ti	me, dete end plece, opinion, death occur	, and due to the c rred et the time, d	euse(s) end ma ate and placa, s	nner as ste and due to t	ted. he cause(	(s)	
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### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dey JAMES MADISON MEBANE. JR. 4:15 P.M. 30, 1999 JULY 4a Fecility Name (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death HOME 7. Age (In yrs. last birthday) BALTIMORE If Under 24 Hrs. 8. Det NURSING BLUE POINT If Under 1 Year 5. Sociei Security Number 8. Date of Birth (Month, Dey, Year) 9. Birthplace (State or Foreign Country) MAR. 25,1909 PENNSYLVANIA 6. Sex 1 M 2 ☐ F Months Deys Min. Hours 90 212 07 0883A Uaual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 X Yes 2 □ No MD. N/ABALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? U.S. OF A. 14. Rece - American Indian, White, etc. 2321 HARLEM AVENUE Merital Status 1 Never Merrled 2 Marrled 3 Widowed 4 Divorced 2 No If Yes, Give Yeer or Detes: 21216 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No Specify: Specify: BLACK Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 12TH U.S. POST OFFICE YEARS MAIL CARRIER 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) ELLA BLANCH STATEN JAMES MADISON MEBANE, SR. 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) MEBANE, III SON 2321 HARLEM AVENUE BALTIMORE. MD. 21216 JAMES M. 20b. Place of Disposition (Name of cemetery, cremetory or other place) ARBUTUS MEM. PARK 20c. Location - City or Town, StaBALTO. 20e. Method of Disposition 1 Buriel 2 Cremetion 3 Removel from Stete 8/3/99 BALTIMORE, MD. Co. Donation 5 Other (Specify) 21. Signeture of Funeral Service Licensee EWIS T. GWYNN 22. Name and Address of Fecility LEWIS T. GWYNN FUNERAL HOME 21215-6393 23e. Pert1. Enfer the disease, or complications real caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. BALTIMORE, MD. Approximete Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ey Carcino ma Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that balleted meters) Due to (or as a consequence of): that initiated events resulting in deeth) Last Due to (or es e consequence of) Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings eveileble prior to completion of cause of death? 24e. Wes en autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Inpatient 2 ER/Outpetient 3 DOA 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b Time of 28d. Describe how Injury occurred 28c. Injury et Work? 1 Naturel 2 Accident 5 Pending 1 ☐ Yea 2 ☐ No Investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Division of Vital Records,

**Physician** 

/Medicai

**Examiner** 

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/Medical Examiner

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State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

(Check only one)

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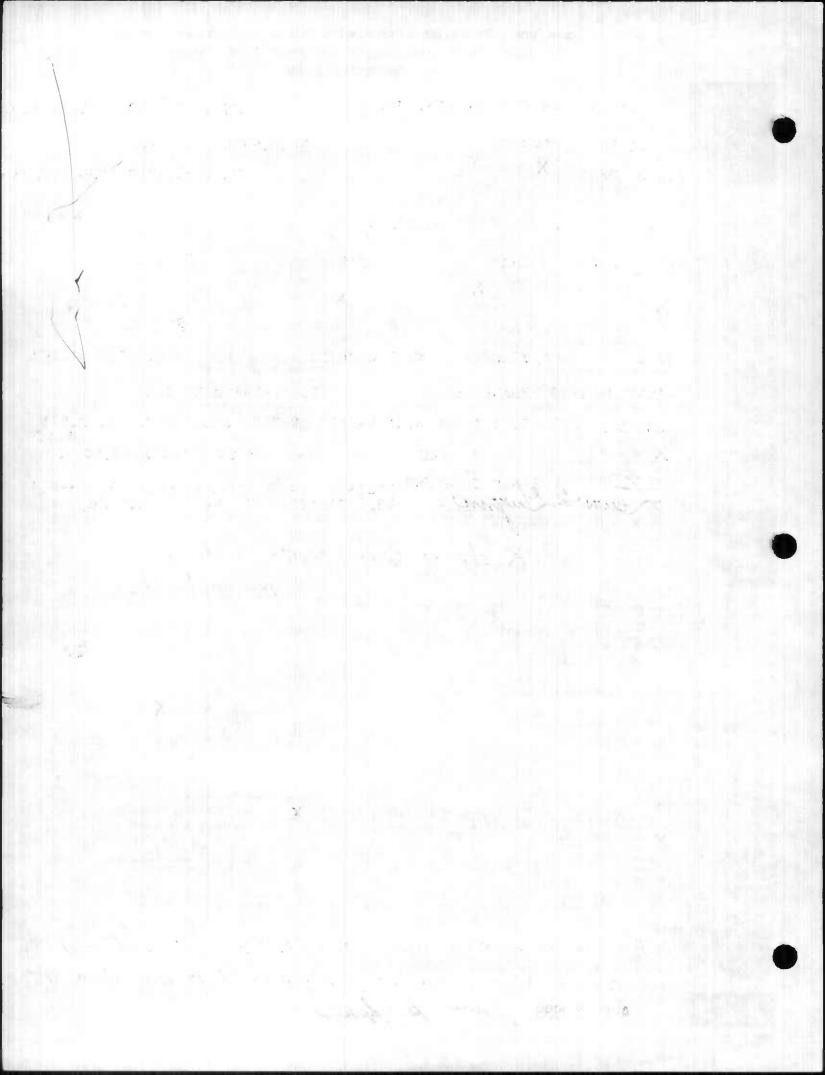
1 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name end eddress of parson who completed cause of deeth (Item 23a) (Type, Print) Amatun

olphin St. Balto MD 212

32..Registrer's Signeture AUG



/Medical **Examiner** certificate be executed The law requires thet

**Physician** 

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**Funeral** 

Director

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Items 23a

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**Physician** 

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Baltimore, Maryland

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hysician end the buriel-transit Box 68760. physician 98 esn Po P.O. signed b Records, pege 2 certificate Division of Vital Physician: this funeral To the Hospital or Attending Pr within 24 hours efter death. To the Funaral Director: After th completely filled in by the funeral

> State Registrar

31. Data filed (Month, Day, Year) AUG 2

30. Nama and address of parson who completed causa of death (Itam 23a) (Type, Print) M. D., STEWART FINNEY 32. Registrar's Signatura

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28d. Dascribe how injury occurred

28c. Injury at Work?

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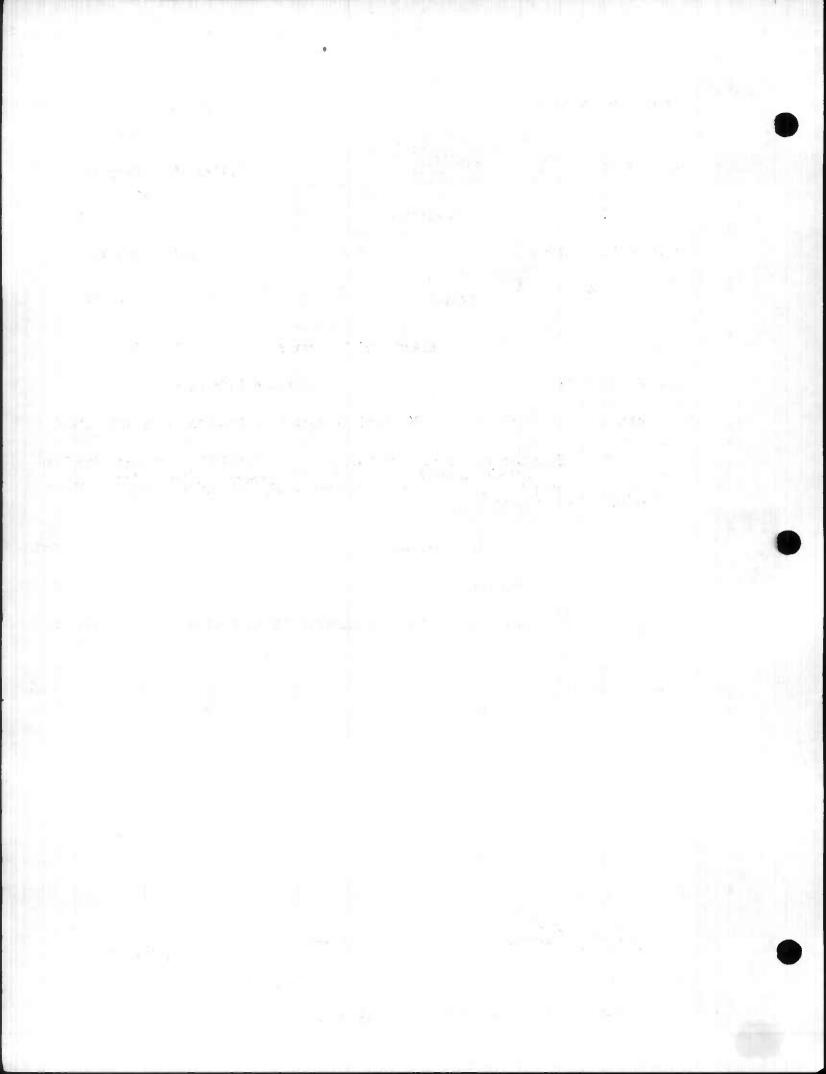
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated.

29c. Licansa number

29d. Data signed (Month, Day, Year)

D38655

7505 OSLER DRIVE, TOWSON, MARYLAND 21204



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Month Year **Physician** LILLIAN MARK JULY 28 10.10 AM 1999 /Medical 4b. City, Town, or Location of Death 4e Facility Nama (If not institution, give street and number) 4c. County of Dea **Examiner** LEVINDALE HEBREW HOME BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Deta of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 □ M 2 💢 F 219-32-0454 MD Director 87 JUNE 11,1912 Usuei Rasidence of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits show 1X Yas 2 No Director N/A 28a-f BALTIMORE 10e. Street and Number 10f Zio Code 10g. Citizen of What Country? ò 6711 PARK HEIGHTS AVENUE #105 23a 21215 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 No If Yas, Giva Herrie Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 1 Nevar Marriad 2 Merried "natural", or 1 ☐ Yes 2X No Specify: WHITE Specify: à 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) REGISTERED NURSE MEDICINE 17 Fathar's Nama (First Middle Last) 18 Mother's Nama (First Middle Maiden Sumame) Be BENJAMIN MATCHAR BERTHA BRAVERMAN 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM MARK / HUSBAND 6711 PARK HEIGHTS AVE. #105 - BALTIMORE, MD 21215 reportant: If Item 27 ny injury or other to 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, Stata Buriai 2 Cramation 3 Ramoval from Stata ARLINGTON CHIZUK AMUNO 7/30/99 4 ☐ Donation 5 ☐ Othar (Specify) BALTIMORE, MD 21. Signature Fungal Service Ligense 22. Nama and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** /Medical Immediata Causa (Final · CANCER LEFT BREAST WITH BONY METASTAGES 18 MONTHO disease or condition rasulting in daath) Examiner Examiner ician and burial-transit Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Dua to (or as a consequence of): physician s the burial Physician/Medical Dua to (or as a consequence of): 980 Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 8 þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? page 2 2 K No 1 ☐ Yas 2 ☐ No 25. Was case rafarred to medical axaminar? 8 26. Place of Death (Check only one) To Hospital: 1 ☐ inpatient 1 Yas 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury st Work? Certification: 1 Naturai 5 Panding invastigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be datamined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 | Homicide

Box 68760. P.O. of Vital Records.

Baltimore, Maryland 21215-0020

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Pages ō

that the death certificate be executed this After Division or Attending death. 24 hours after deal Funeral Director: Hospital

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29b. Signatura and title of certifier >E4twan PHYSICIAN

ATTENDING

29c. License number

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12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Day, Year)

30. Name and addrass or person who complated causa of death (Item 23a) (Type, Print)

2434 WEST BELVERDERE AVENUE BALTIMORE MD SET HTWAR MD. LEVINDALE

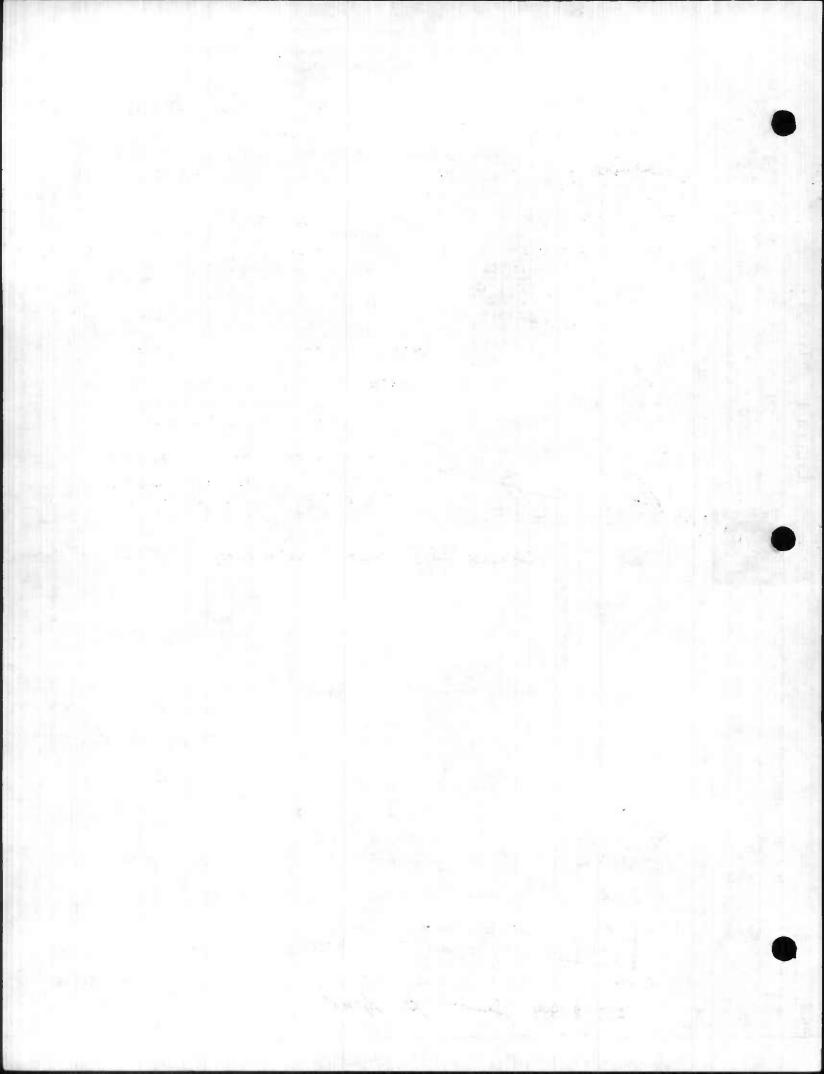
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Birthplace (Stata or Foreign Country)

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24b. Were autopsy tindings available prior to completion of cause of death?

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29d. Date signed (Month, Day, Year)

PATUXENT PKWY COLUMBIA, MD 21044

Approximata Intarval Batween Onset and Death

10d. Insida City Limits

1 ☐ Yes 2 No

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14. Race - American Indian, Black, White, atc.

Specify: White

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 76 MEREDITH DONNIE 25 JULY /Medical 4b. City, Town, or Location of Death Facility Nama (If not institution, giva street and number 4c. County of Death **Examiner** COLUMBIA HOWARD COUNTY GENERAL HOWARD HOSPITAL

**Funeral** 

**Physician** /Medical Examiner

Baltimore, Maryland 21215-0020

sician and burial-transit The law requires that the death certificate be executed Box 68760. USB as P.O. Records, certificate of Vital Physician: this funeral After Division the

Physician/Medical Examiner Completed by Be Medical Certification: To within 24 hours after death. To the Funeral Director: A filled in by completely

29b. Signature and title of certifie

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If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) 10 M X F Months Days Hours Yrs. 412-66-5172 Director ULY 4, 1942 Usual Residence of Decedent 10a. Stata 10b. County 10c, City. Town or Location MD Howard Columbia Directo 288-7 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? munt be n 21044 10758 Evening Wind Court USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No. If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 72 hours after 1 Nevar Married 2 Married 1 ☐ Yes 2 ☑ No If Yas, Give X Year or Dates: 8 1☐ Yes 2√No PV 3 Widowed 4 Divorced "natural", il Hygiene. other then "neturn ent, the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working tita. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Accountant Veterinary Medicine 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumema) Pages 1 and 2 should be I ment of Health and Mental I ant: If hem 27 is marked or David Eldredge Starley Ella Mae (Ussery) 19a. Informent's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rurat Route Number, City or Town, Stata, Zip Coda) 10758 Evening Wind Court, Columbia, MD 21044 William C. Meredith (Husband) July 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State Department of Important: If It any Injury or o 1 Buriai 2 Cremation 3 Removal from Stata 4 Donation 5 Othar (Specify) 28, 1999 Clarksville, MD Columbia Mem. Park 21. Signature of Funaral Service Licenses 22. Nama and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Rd. Columbia, MD 23a. Part1. Entar tha disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or haart failura. List only one cause on each line. Immediate Cause (Finel diseasa or condition rasulting in deeth) LNFARCTION MYDEARDIAL ARRINTUMIA Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of UNCERTAIN ETIDLOGY ARDIOMYOPATHY OF Due to (or as a consequence of Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION 24a. Was an autopsy performed? OBESITY 2 No 1 Yas 25. Was casa rafarred to medical examiner? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of Injury 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation 1 Yes 2 No 2 Accidant 6 Could not be datarmined 28f. Location (Street and Number or Rural Route Number, City or Town, Steta) 3 ☐ Suicide 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 ☐ Homicide o the Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. 29a. Certifiar (Check only

m.D.

32. Registrar's Signa

11085 LITTLE

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

M.D.

State Registrar

**DHMH 16 Rev 6/95** 

29c. License number

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Neme (First, Middle, Last) 2. Data of Death 3. Time of Death Month Yaai **Physician** 1999 Penelope Sara Martin 29, 5:18 am July /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Howard 6308 Burnt Mountain Path Columbia If Undar 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 20, 19 Birthplece (State or Foreign Country)
 MA 5. Social Security Number 7. Aga (In yrs. lest birthday) **Funeral** Deys Months Hours 1 □ M 2 🕅 F Yrs. Director 282-50-4067 46 Usuai Rasidance of Decedant Pages 1 and 2 should be filed within 72 hours aftar death with the Manyland nant of Health and Mental Hyglene.
Instit if Item 27 is marked other than "naturs!, or itema 28 or 28e-5 show may or other transman." 10a. State 10c. City. Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at 1 Yas 2 No MD Howard Columbia Director 10e. Street and Number 10g. Citizan of What Country? 10f. Zip Code 21045 6308 Burnt Mountain Path U.S.A. Funeral Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, atc.) 14. Race - American Indian, Bleck, White, etc. 12. Was Decedent Evar in U,S. Armed Forces? 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes 2 No Specify: Specify: Black by 3 Widowed 4 Divorced Yaar or Dates: Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 18b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondary (0-12) Hewlett 5+ Technical Consultant 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Lydia Chenault Harry Taylor Martin 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Columbia, Maryland 21045 6308 Burnt Mountain Path, Candice Martin (Sister) 20b. Plece of Disposition (Neme of cametery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition 1 Burial 2 Cremetion 3 Removel from Stete
4 Donation 5 Other (Specify) permit. Page Department of Important: If any Injury or once. allimore Washington Crem. 7/30/99 Laurel, Maryland 22. Name and Address of Fecility Witzke Funeral Homes, Inc. 21. Signature of Funeral Service Li 5555 Twin Knolls Road, Columbia, MD 21045 23a. Part1. Enter the disease, or complications that caused me shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset end Deeth Taeth. Do not enter the mode of dylng, such as cerdiec or respiretory errest, **Physician** Candiopulmonary annest
Due to (or es e lonsequence ot):
Metastatic breast canc /Medical fmmediate Cause (Final disease or condition resulting in death) Examiner reast cancer Examiner attending physician and for use as the bunal-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Physician/Medical Due to (or as a consequence of) signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ should I 24b. Were autopsy tindings aveilable prior to 24e. Wes an autopsy performed? Completed completion of causa of death? cartificate has t 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this cartifica Be 25. Was case referred to medical exeminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 AResidence 8 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of 28c. fnjury at Work? 1 Neturel 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, fectory, offica building, etc. (Specify) in 24 hou.
The Funeral Direction of the control of 2 4 Homicide Medical 29a. Certifier 11 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) end menner es steted. To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or Investigation, In my opinion, deeth occurred at the time, dete end pleca, end due to the ceuse(s) end manner steted. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifier

State Registrar DHMH 16 Rev 6/95

The law requires that the death certificate be asscuted

Division of Vital Records, P.O. Box 68760,

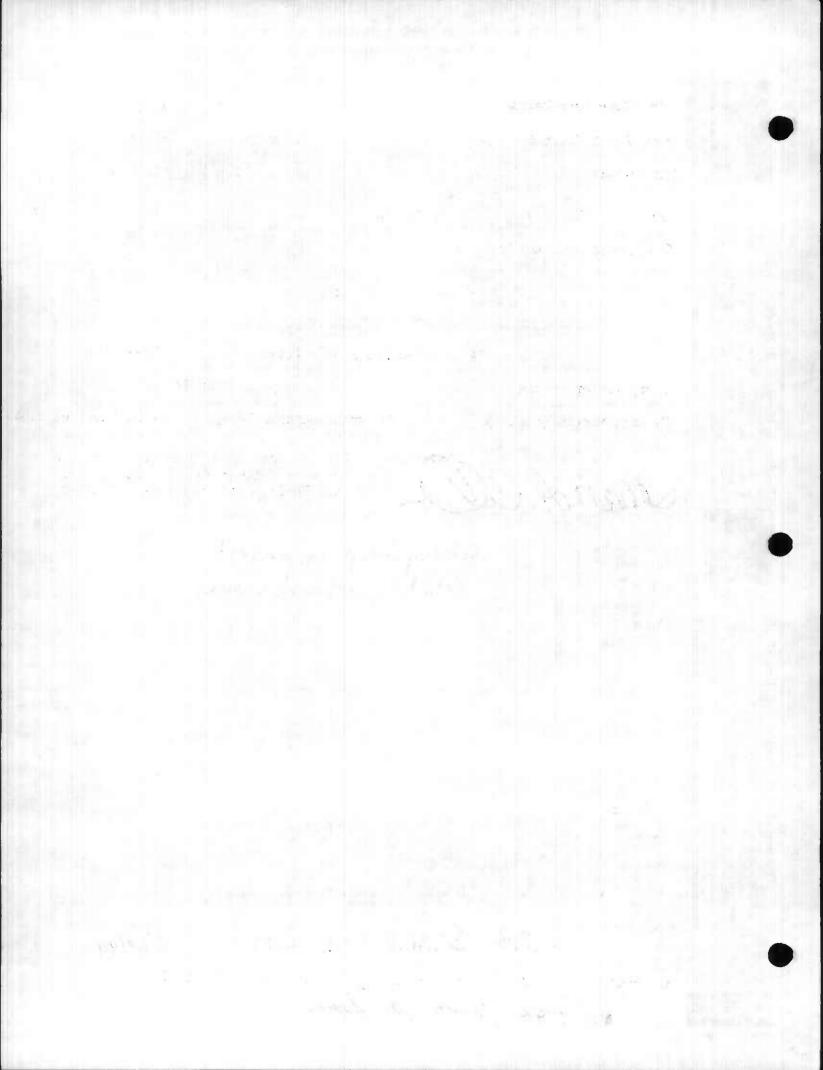
Baltimore, Maryland 21215-0020

31. Date filed (Month, 'Day, Year)

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

32. Registrer's Signeture

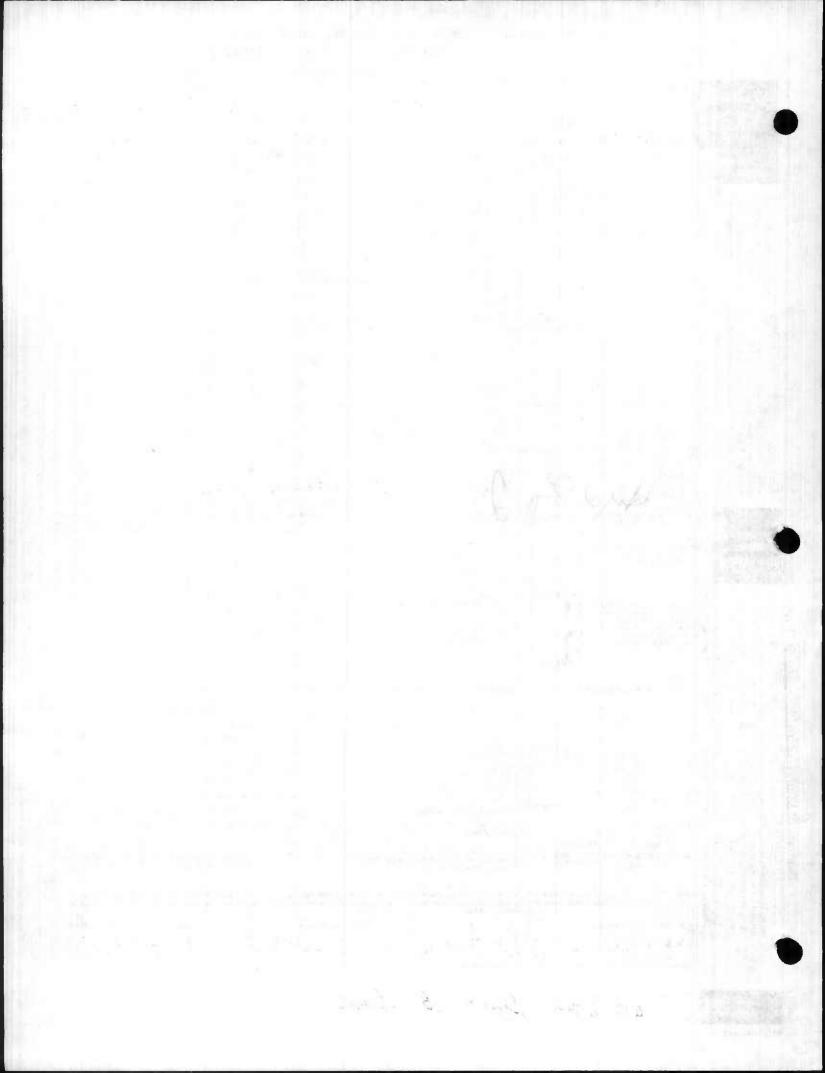
Said Baidas, M.D., 3800 Reservoir Road NW, Washington, D.C. 20007 oaks



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Physicia /Medica Examine		4. December 1. Name (Class & Color), Co.						Reg. No.		
/Medica	n	Decedent's Neme (First, Middle, Las		***			2. Dete of D	eath Dey	Yeer	3. Time of Deeth
Examine	_		PFORD	MU	RPHY		JULY	30	1999	12:50 pm
		4e. Fecility Neme (If not institution, give CHARLESTOWN CARE	CENTER			BALTIM			ty of Deeth BAL	TIMORE
Funeral Director		201-10-3334	7. Age (I	n yrs. lest birth 73 Yı	Mont	ths Deys Hours M	Irs. 8. Dete of B (Month, D March	<sup>rth</sup> ey, Year) 20, 192	9. Birthi Cour Pen	plece (State or Foreign http) INSYTVania
ě ==	-	Usuel Residence of Decedent  10a. Stete 10b. County	11	0c. City, Town	or Location					10d. Inside City Limits
r 28a-f show notified at	ţ	Maryland Baltim	nore		Ra	ltimore				1 ☐ Yes 2 🖔 No
or 28a	Director	10e. Street end Number				Zip Code		10g. Citizen o	f Whet Cou	ntry?
23a c	a	709 Maiden Choic	e Lane		21228			USA	1	
al', or items Examinar or	by Funeral	11. Marital Stetus  1 Never Merried 2 Married  3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	er In U,S.	<ul> <li>13. Was Decedent of Hispenic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)</li> <li>1 ☐ Yes 2 ☐ No Specify:</li> </ul>				ace - Americack, White,	can indien, etc. ite
natural', so cal Ex	Completed		15. Decedent's Education (Specify only highest grade completed)				vorkina	16b. Kind of	Business/In	dustry
then.	ă	Elementery/Secondery (0-12)	College (1-4or 5+)			work done during most of w T use retired)				
P. P. S.	ပ္ပ	17. Fether's Neme (First, Middle, Lest)	4		Span1.	sh Teacher	lame (First, Middle			Education
la de de	Be	Ellis	Stor	pford				e, Meiden Surri	Leid	1/
th end Mer 7 is marks traumatic	2	19e. Informent's Name/Reletionship (T			Meiling Addr	ress (Street end Number or		ner City or Tow		y
		Kathleen White	(Daughter)		_	ble Beach Dr				
Peges 1 and ent of Health int if item 27 iry or other to		20e. Method of Disposition		20b. Plece of D	Disposition (		Dete	20c. Location		
	1	1  Burlei 2  Cremetion 3  □ F 4  Donetion 5  Other (Specify)				urg Cem.	8/3/99	Harrish	ourg,	Pennsylvan:
Departr Importa any inju		21. Signature of Funeral Service Liquid	ee /		Stall	end Address of Fecility lings Funeral				
	1	23e. Pert1. Enter the diffsase, or comp shock, or heart failura. List only o	ications that gaused the	e deeth. Do no	3111 t enter the n	Mountain Roa	d Pasade liac or respiretory	na, MD.	2112	Approximete
nysician	1	SHOCK, OF NOOT IMMUNE. LIME ONLY O	ourse orreech line.						all and	Intervel Between Onset end Deeth
Medical		Immediete Ceuse (Finei disease or condition	5	EPS1	S					DAYS
kaminer		resulting in deeth)  Due to (or es e consequence of):								
in the state of			b						i	
physician and s the burial-transit	Examiner	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events  Due to (or as a consequence of):								
nding physician and use as the bunal-tran	8	thet initieted events resulting in deeth) Lest	Due	o to (or es e cor	s e consequence of):					
lendir or use	any		d,							
he at	Physician	Pert il. Other significant conditions con	ntributing to death but n	ot resulting in ti	he underlyin	ng cause given in Pert i.	23b. Did	tobacco uae c	ontribute to	o the cause of death?
signed by the attending pd be deteched for use as	Dy Phy	CEREBROUPS	CULAR D	ISE A	2E		1	Yee 2 No	3□ Pro	bably 4 Unknown
2 shoul	completed						24e. We	s en eutopsy ormed?	av	ere autopsy findings eileble prior to impletion of cause deeth?
page page							10	Yes 2 No	1[	☐Yes 2☐No
director, page 2		25. Wes case referred to medical exeminer?				26. Piece of C	eeth (Check only	one)		
00	2	1 Yes 2 No	lospitel: 1 Inpatient	2□ ER/Outp	atient 3	DOA Other: 42 Nursing	Home 5 ☐ Res	idence 6 🗆 O	ther (Specif	y)
ther the	5	27. Menner of Deeth 1 ☑ Neturel 5 ☐ Pending	28e. Dete of injury (Month, Dey Ye	28b. Tim inju	ıry	28c. injury et Work?	28d. Describe	how injury occ	urred	
is effer death.  In Director: After this certific led in by the funeral director, led in by the funeral director.  Cortification: To Be	IIICAL	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Plece of injury building, etc. (5	- At home, fam	M , street, fec	1 Yes 2 No	28f. Location City or To	(Street and Num wn, State)	ber or Rure	al Route Number,
within 24 hours efter death. To the Funeral Director: Affer thi completely filled in by the funeral Medical Certification:	200	29e. Certifier 1 Certifying Phys	sician: To the best of m	y knowledge, d	leeth occurr	red et the time, dete end ple	ce, end due to the	cause(s) end r	nanner as s	tated.
the Funer npletely fill		one)	end menner steted			tion, in my opinion, deeth oc	curred et the time			
To the	2	29b. Signeture and title of certifier	1.1	_		29c. License number	7	29d. Dete sign		
		· Useni	JUNI	$\wedge$		D2647	5	JULY	30,	1999
		30. Neme end eddress of person who od Bernard Koziovsky	MD 711	Maiden		ce Lane, Cato	nsville,	Md. 21	228	
State		31. Dete filed (Month, Dey, Year)  ALIG 2 1999	32. Registrer's	Signeture	do	als				



## Piease Type or Print in Biack Indeiible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

9	0	0	01	1 1
,	3	3	24	14

Phy	sicia	an
/M	edic	al
Exa	ımin	er

McDaniel, Jr. Moses 4a Facility Name (If not institution, give street and number)

2. Dete of Death Dey 1999 Month JULY 28,

3. Tima of Death

04:39 AM

**Funeral** Director

must be notified at

Rems.

"netural", or Item hours after

Hygiene.

permit. Pages 1 and 2 should be file.
Department of Heelth and Mental th, Important: if Item 27 is marked oth any Injury or other traumatic event once.

death

aitimore, Maryjand 21215-0020

Box 68760

P.O.

Records,

Vitai

of

Division

Dir

Funeral

p

Completed

Be

2

JOHN HOPKINS BAYVIEW 5. Sociel Security Number

1. Decedent's Neme (First, Middle, Last)

If Under 1 Year 7. Age (In yrs. last birthday) Months 1 M 2 □ F 27 Vre

BALTIMORE If Under 24 Hrs.

4b. City, Town, or Location of Death

4c. County of Death

220-78-0741

10b. County

10c. City, Town or Location

10f. Zip Code

21206

Days

Birthplece (State or Foreign Country)

10d. Inside City Limits

Usuel Residence of Decedent 10a. Stete

MD

NA

Baltimore

1 Yas 2 No 10g. Citizan of What Country?

USA

10e. Street and Number 5010 Denview Way Apt.

1 Never Merried 2 Merried

12. Was Decedent Ever in U,S. Amed Forces? 1 Yes 2 No If Yes, Giva Year or Dates:

 Wes Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ Yes 2 ☐XNo Specify:

 Race - American Indien, Black, Whita, etc. Specify: Blakc

3 ☐ Widowed 4 ☐ Divorced

15. Decedent's Education (Specify only highest grede completed)

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+)

16b. Kind of Business/Industry

High Sch. Grad

Electrician Apprentice 18. Mother's Neme (First, Middla, Maiden Surnama)

Free State Electric

Bowlding

17. Father's Name (First, Middle, Last)

Moses

McDaniel, Sr.

Sharon

19b. Meiling Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code)
5008 Denview Way Apt. "E" Baltimore, MD 21206

19a. Informent's Neme/Reletionship (Type, Print)

Bowlding Sharon

20b Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State MD

20e. Method of Disposition

Immediate Cause (Finel diseese or condition resulting in death)

1X Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify)

Garrison Forest VA Cem. 08-03-99 Owings Mills, 22. Neme end Address of Facility Baltimore, Maryland 21202

21. Signature of Funaral Service Licensee

WM.C.March FH 1101 E. North Avenue

Approximata Intervel Between Onset end Deeth 23a. Part1. Enlar the disease, or complications that caused the deeth. Do not entar tha mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line.

**Physician** /Medical Examiner

signed by the

page 2

certificata

this

After

in 24 hours after death.

The Funeral Director: After view illed in but the

To the To To the T

Attending Physician:

À

Completed

Be

Certification: To

that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical au the

Due to (or es e consequence of)

Due to (or as e consequence of).

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part t.

23b. Dtd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Yes 2 No

25. Was case referred to medical 1 No 2 No

5 Pending

6 Could not be determined

27. Menner of Death

1 Natural
2 Accident

3 ☐ Suicide

4 Homicida

Hospitel: 1 Impatient 2 □ ER/Outpatient 3 □ DOA 28a. Dete of Injury (Month, Dey Year) investigation 2/20/75

28b. Time of Injury 1826

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury et Work? 1 Yas 2 □ No

28d. Describe how Injury occurred suffect burred in Electrical the atwork

29a. Certifier

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) workplace 281. Location (Street and Number or Rurel Rouge Number City or Town, State) 300 Just Lexing Street Milliams, May to Lexingla

Medical (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.

\*\*I Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier

29c. License number

OCME

29d. Date signed (Month, Day, Year)

30. Name and address of pe

of death (Item 23a) (Type, Print)

JULY 29, 1999

THEODORE MICHAN 31. Date filed (Month, Day, Year)

Aegistrer's Signetura 111 Penn Street, Baltimore, Maryland 21201

26. Place of Death (Check only ona)

State Registrar

**DHMH 16 Rev 6/95** 

**ORIGINAL** 

#### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last), 2 Date of Death 24,1999 **Physician** orothy /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner HOSPIta Sinai alti more If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number Birthplaca (State or Foreign Country) **Funeral** Days Hours 1□M 2XF 214-44-8322 Yes Md Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 Yes 2 No NA Director Ma Herre 23s or 28s-1 Der must be notifi 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 Avenue NOME Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11 Marifal Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black P 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hospital Elementery/Secondary (0-12) College (1-4or 5+) 124 grade NA 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Eugene eney rockets 19a\_Informant's Neme/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City of Town, State, Zip Code) tant: If Hem 27 is Bernice Sister inden eights 13a 1to, red 21215 5224 erry 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Neme of Date 20c. Location - City or Town, State 1 emonal lack 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Wabas 20140, Ha 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Physician Immediate Cause (Finel diseese or condition resulting in death) /Medical Examiner Examiner MODEL ician and burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? been signed by should be detac 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificate has 25 No 1 🗆 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 8 26. Placa of Death (Check only one) Hospitel: 1 ☐ Yes 25 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient To 2 ER/Outpatient 3D DOA this Manner of Death 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred Injury at Work? To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After 5 Pending investigation 1 Yes 2 - No 2 Accident 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stele) 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier completely (Check only one) 29b. Signature and aftle of certifier 29d. Date signed (Month, Day, Year)

Registrar

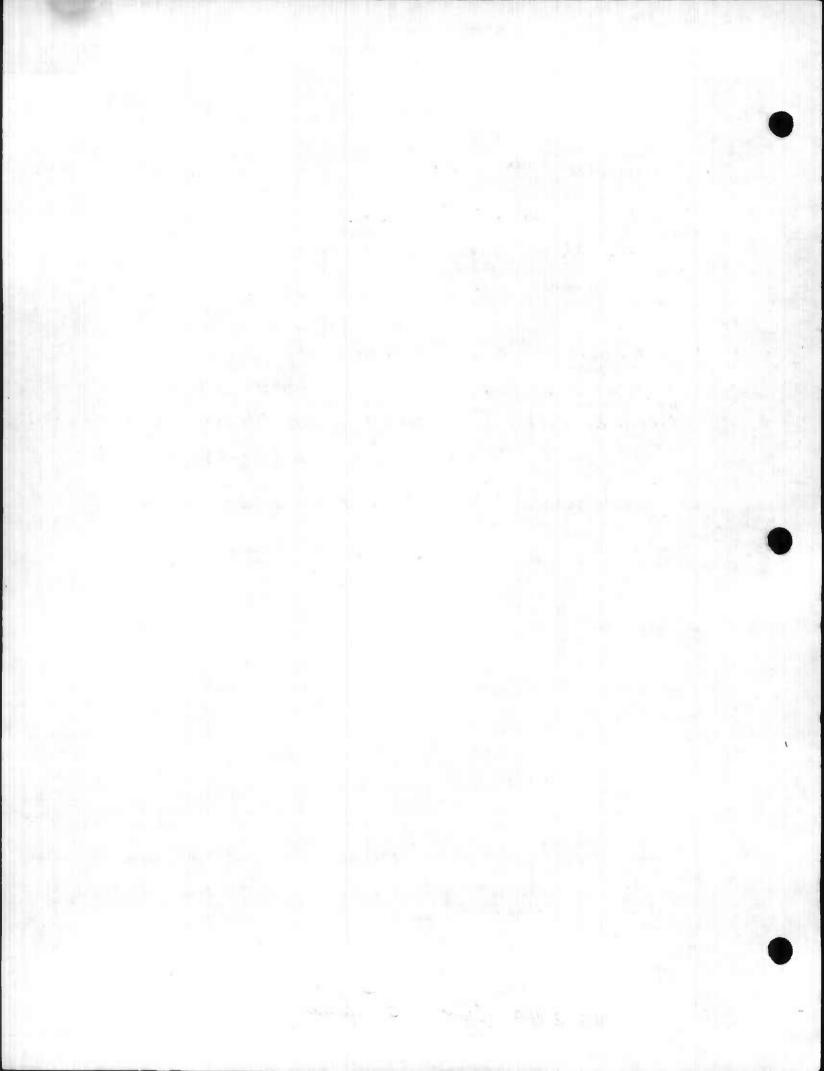
State

31. Date filed (Month, Day, "Year) -

Ave Baltimore, n

leted cause of death (Item 23a) (Type, Print)

32. Redistrar's Signature



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Edward J. McDermott 5:28A.M 2 July /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a, Fecility Neme (If not institution, give street end number) Examiner Baltimore Hunder 24 Hrs. Hours Min. April 15,1936 7. Age (In yrs. lest birthdey) Center avare 6. Sex 5. Sociel Security Number Birthplece (State or Foreign Country) **Funeral** Months Deys 1 M 2□ F 63 212 32 6614 Maryland Director Usuel Residence of Decedent the Maryland 10h County 10c. City, Town or Location 10d. Inaide City Limits 10a State 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Baltimore Middle River 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? with 7346 Chesapeake Road 21220 USA Dermott, Edward Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 XNever Married 2 ☐ Married Specify: White 1 ☐ Yes 2 TNo Specify: 2 3 ☐ Widowed 4 ☐ Divorced al Hygiene. 1958–60 | 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondary (0-12) Equipment Operator Construction 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Pages 1 and 2 should be Health and Mental Edward Joseph McDermott Rappold Muriel 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jo Anne Kahler (cousin) 101 Bengies Road Middle River Maryland 21220 altimore. 20b. Pleca of Disposition (Neme of cemetery, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removal from State
4 Donaton 5 Other (Specify) Holly Hill Mem. Gardens 7/30/99 Baltimore Co., Md 21, Signature of Funeral Service License zź. Name and Address of Fecility Bruzdzinski Funeral Home PA 1407 Old eastern Avenue Essex, Maryland 21221 Hone that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, cause contact hina. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final Pheumania disease or condition resulting in death) Examiner Examiner Sema physician and the bunal-transit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? P.0. signed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. 24b. Were autopsy findings evellable prior to completion of cause of death? Completed 24e. Wes en autopsy 1 Yes 1 ☐ Yea 2 ☐ No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific funeral director, 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2N No 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred Certification: 28c. Injury at Work? 1 Neturel 2 Accident 5 Pending Investigation 3 Sulcide 6 Could not be determined 28f. Location (Streef end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) end menner ateted. To the Hospi within 24 hou To the Funer completely lil Medical 29a. Certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signature and title of certifier 050228 30. Neme and eddress of person who completed cause of deeth (Item 23a)\_(Type, Print)

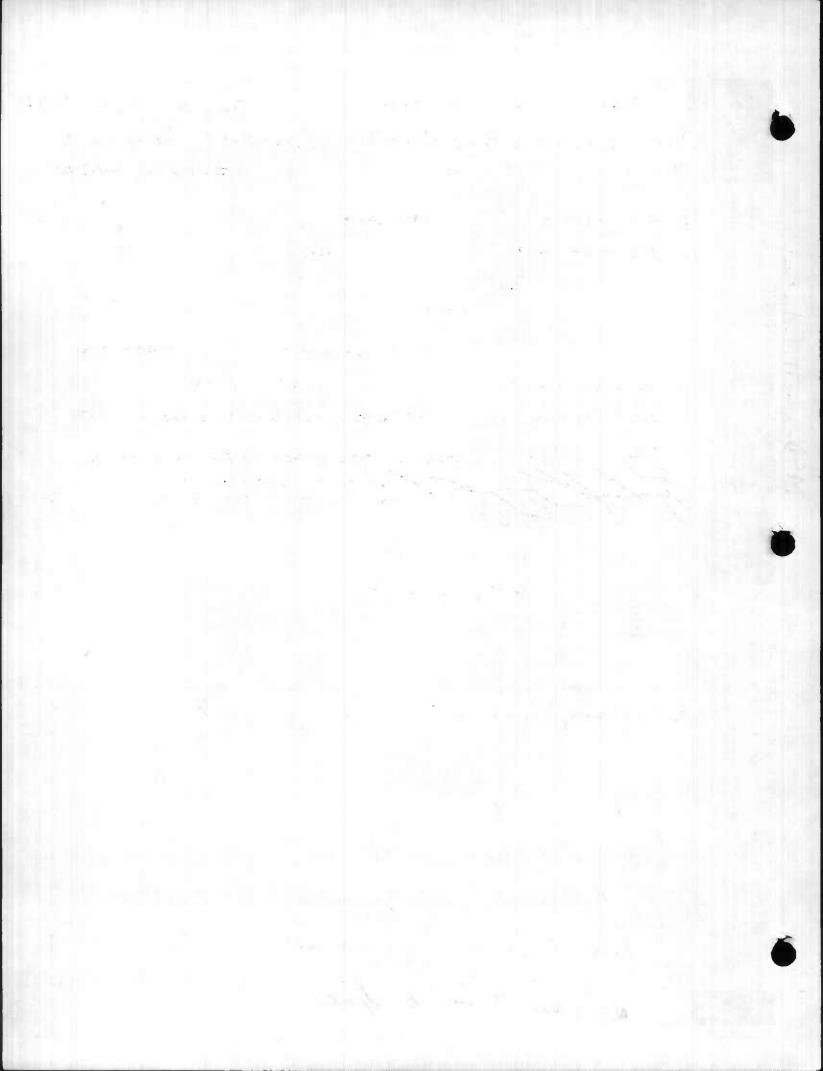
Klin Square Drive Baltimore MD21237

State Registrar 31. Dete filed (Month, Day), Yeer)

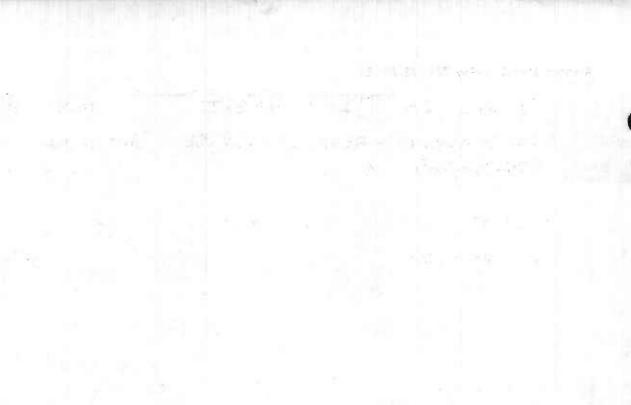
AUG

1999

32 Registrer's Signeture



Amer	dec	I Item#1 perPhyG774 8/26			ent of Health an ate of Death		ene 9	9 24 4	+			
Physic /Medi Exami	cal	1. Decedant's Nama (First, Middle, Last VIRGINIA  4a. Facility Nama (If not institution, give LORIEN NURSING	street and number)	MANSK	edomanski I 4b. City, Town,	2. Data of Death Month JULY , or Location of Death	Day 8					
Funeral Director		5. Social Sacurity Number 6. Sa	7. Aga (In yrs. 82	Yrs.	ndar 1 Yaar II Undar 24 ths Days Hours I	Hrs. 8. Data of Birth Min. (Month, Day, March 19		9. Birthplaca (State or For Country) Virginia	reign			
Maryland a-f ehow	Ba-f show	10a. Stata 10b. County Maryland		ty, Town or Location				10d. Insida City Lir 1 XYas 2 □				
with the	Dire	10e. Street and Numbar			. Zip Coda		g. Citizan of W					
5-0020 72 hours efter death with the Maryland natural; or items 23s or 28s-f show deal Examiner must be incitied at	by Funeral	11. Marital Status  1□ Navar Marriad 2□ Married  3□ Widowed 4 ᡚ Divorced	12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No		21206 ecedant of Hispanic Origin's specify Cuban, Maxicen, P		14. Race	- Amarican Indian, , White, atc.				
21215-0020 d within 72 hours ef giene. or then "netural", or for wed	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	rade completed)  College (1-4or 5+)  (Give kind of work done during most of work life. DO NOT use retired)				6b. Kind of Bus					
Maryland 212 d 2 should be filed within th and Mental Hygiene. T is marked other than traumatic event, the M	To Be Co	7 17. Fathar's Nama (First, Middle, Last) Clyde Fritter	Waitress  18. Mothar's Nama (First, Min  Bollie Bak				estaur aiden Surmarne					
Md 2 and 2 a	_	19a. Informant's Name/Ralationship (Ty	ki 20b F	Same a	rass (Street and Number of	r Rural Route Number,						
Baltimore, pemit. Pages 1 at Department of Hea Important: if Item; any Injury or othe		4 ☐ Donation 5 ☐ Other (Specify)	Janet Niedomanski  Oa. Mathod of Disposition  15 Burial 2 Cramation 3 Ramoval from Stata  4 Donation 5 Othar (Specify)  21. Signatura of Funaral Sarvica Licansea  20b. Placa of Disposition (Name of cematery, crematory or othar place) uly 21, 1999  Chicamuxen United Methodist Chicamuxer  22. Nama and Address of Facility  Williams Funeral Home, P.A.									
Physician /Medical Examiner	9r	23a. Part 1. Entar the disease, or complishock, or hard dilure. List only or immediate Causa (Finel disaasa or condition resulting in death)	Cur	th. Do not antar tha	Hear	diac or respiretory erras	st,	Approximate Intervel Between Onsat and Death	ì			
58760, cate be executed physician and the bunal-transit	ai Examiner	Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause, (Disease or injury	Dua to (c	or as a consequance								
.O. BOX 68760, the death certificate be ex y the attending physician sched for use as the burial	an/Medical	that initiated avants rasulting In death) Last	Due to (or as a consequence of):									
O a the	by Physician/M	Part II. Other eignificant conditions con	atributing to death but not res	ulting In the underlyi	ng cause givan In Part I.			ribute to the cause of dec				
aw requir	Completed b					24a. Was an perform	autopsy ed?	24b. Were autopsy finding available prior to completion of causa of death?				
Vital Rollinis Incidente de rector, page	Be Con	25. Was casa referred to medical		•	26 Place of	1 ☐ Yas		1 ☐ Yas 2 ☐ No				
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Division of a death.  I Director: After this of in by the funeral	Certification:	27. Manner of Death  1 Natural 5 Panding 2 Accidant Invastigation 3 Suicida 6 Could not be	28e. Deta of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 Yas 2 No	28d. Describe how		d r or Rurai Route Number,				
DIV To the Hospital or A within 24 hours effer To the Funeral Direc completely filled in by		4 Homicida dataminad	28a. Place of Injury - At his building, atc. (Specification)	y) wledge, deeth occur	red at the time, date and n	City or Town,	Stata)	hafata sa nan				
the Ho hin 24 the Fu	Medical	one) 2 Medical Examir	ner: On the basis of exemina and mannar stated.	tion and/or invastiga	tion, in my opinion, death o	occurred at tha time, det	e and plece, ar	d dua to the causa(s)				
To with	-	29b. Signature and the or partifier			29c. Licansa number D43725 09 Back	290	7/20	(Month, Day, Year) 199 Mp 21	רכים			
		7 7 1	mpleted cause of deeth (Itan	23a) (Type, Print)	09 Back	River Ne	ek Rd	Bullinore	221			
Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	itura	Soon Kel							



State of Maryland / Department of Health and Mental Hygiene 9 9 21 15 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July **Physician** Charles John Pullara 3:45 pm 30 1999 /Medical 4e Fecility Name (If not Institution, give street and number)
Union Memorial Hospital 4b. City, Town, or Location of Death Baltimore 4c County of Death Examiner 5. Social Security Number If Under 1 Yeer 8. Dete of Birth (Month, Day, y 01/05/1914 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 11XM 2□ F Months Deys Hours 85 Mary land 220-18-7573 Yrs. Director Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Example must be notified an once. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Baltimore N/A 1 Yes 2 No MD Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21213 3615 Brehms Lane Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, Biack, White, etc. 11. Meritel Stetus 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Barber Self-employed 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Ignatius Pullara Carmela Bonica 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Charles R. Pullara/Son 8651 Hoerner Avenue, Baltimore, Maryland 21234 20b. Place of Disposition (Name of 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 Duriel 2 Cremetion 3 Removel from State Dulaney Valley Mem. Gdns.08/03/99Timonium, Maryland 4 Donation 5 DOther (Specify) 22. Name end Address of Fecility Leonard J. Ruck, Inc. 21. Signeture of Funeral Service Licensee Christina L. David 5305 Harford Road, Baltimore, Maryland 21214 Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** ADULD RESPIRATORY DISTRESS SYNDROM /Medical Immediete Cause (Final disease or condition resulting in death) Examiner Due to (or es e consequence of): Examiner 100945 DREUMONIa attending physician and for use as the burial-transit that the death certificate be axecuted Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or es e consequence of): signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No CEREBROVASCULAR 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? i cartificate has b director, page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this cartifica stely filled in by the funeral director. 25. Was case referred to medicel 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 10 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Dete of injury (Month, Day Year) 28c. injury et Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ HomicIde To the Hospital or within 24 hours aff To the Funeral Di completely filled in 29a, Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, end due to the cause(s) and manner es stated. Medical

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end menner steted.

UNION MEMORIAL HOSPITAL

29d. Dete signed (Month, Dey, Year)

Hein, MD AT 2438946

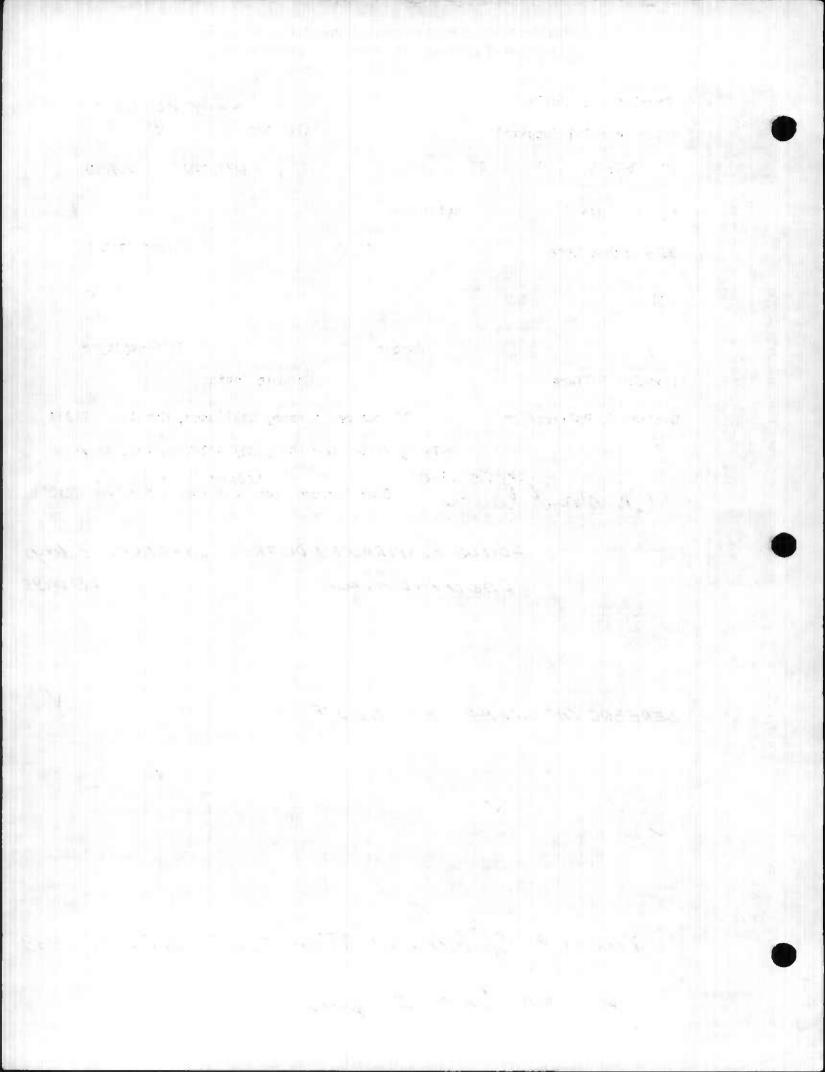
State Registrar (Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed gause of death (Item 23a) (Type, Print)

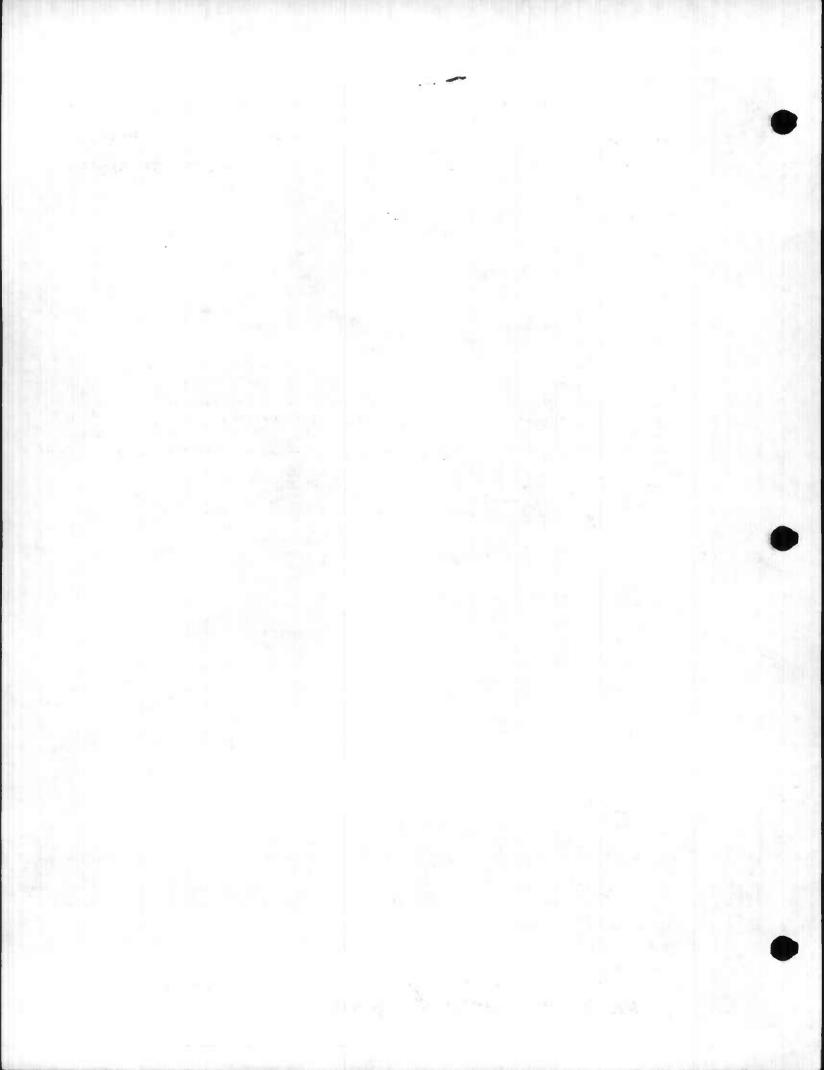
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32. Registrar's Signature



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1. Deced	ent's Nama (F	irst, Middle, La	st)	-	Cer	tificate	of	Death	2. Date of De	Reg. No.	<i> - - - - - - - - -</i>	3. Tima of Death
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/Medica	4 m F m - 262		Rae P	<u>inzuti</u> e street and numb	ner)			1	lb. City, Town, or L	2		of Death	J. 13211
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2 44 14		et and Numbe Waldo	r Drive				10f. Zip (	ode 2123	34		10g. Citizen of What Country? United States		
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and and and and and and and and and and	19e. fnfo	rmant's Name	Ralationship (	Type, Print)					and Number or Ru				Code)
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Baltimore, permit. Pages 1 at Department of Hea Important: If them any Injury or other otics.			Service Licen		Leonard J. Ruck, Inc. Funeral Home 5305 Harford Road Baltimore, Maryland								
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E & \$1		er of Death letural 5 Accident	Pending invastigation	till till till till till till till till	Injury Day Year)	28b. Time of Injury	M 28	c. Injur Wor	yet k? Yas 2 □ No	28d. Dascribe	how injury occur	rred	
Division or To the Hospital or Attending Phi within 24 hours after death. To the Fureral Director: After thi completely filled in by the funeral Medical Certification:	3 🗆 \$ 4 🗆 }	Suicide 6 Homicide	Could not be determined	28a. Place of	Injury - At he , atc. (Specif	ome, farm, stre	eet, fectory,	office		28f. Location ( City or To	Street and Numi wn, State)	ber or Rural	Route Number,
he Hospit in 24 hours he Funera pletely fills		ck only 2			s of examina				na, data and place pinion, deeth occu				
Vithin Coth	29b. Signature and titler of certifier 29c. License number								29d. Dafe signed (Month, Day, Year)				
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	30. Name	and address		completed cause of				lica	al Center	7620	York Ro	ed 21	204
State	31. Data	filed (Month D	ay. 500 199	3L. Reg	istrar's Signa	ture	Loon	6)	/	r. M.Re.M.			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. AMENDED ITEM #26 PER MD G774 8/2/99 AH 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death ulleN O Th **Physician** e dward /Medical 4a Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 40 0 If Undar 1 Yaer If Undar 24 Hrs. 7. Aga (In yrs. last birthday) 5. Social Security Number 6. Sax Date of Birth (Month, Day, Year) Birthplace (Steta or Foreign Country) **Funeral** Deys Hours 1 M 20 F Yrs Director Mic 407 Usual Rasidance of Decedant the Manyland 10a. Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-1 show any inlury or other traumatic event, the Medical Empire ment by notified at 134/10 1 Yas 2 No Director mu. 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 4,5,A 2/2/5

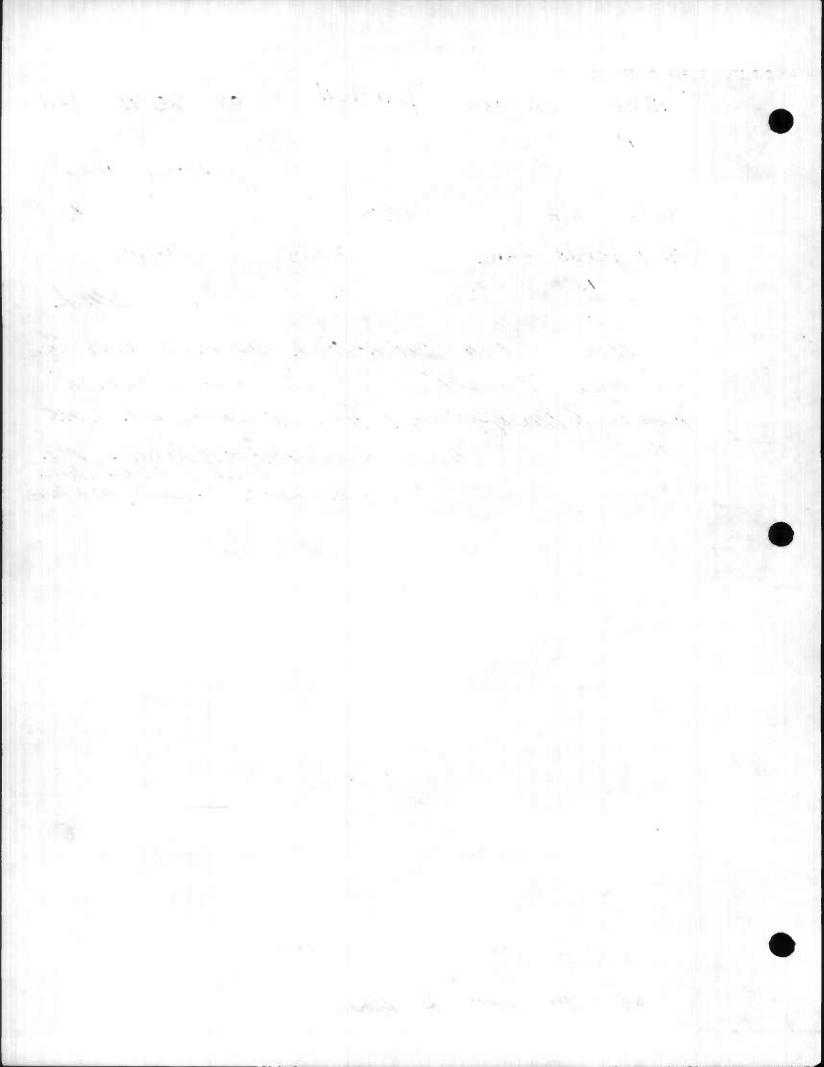
13. Wes Decedent of Hispanic Origin? (Specify Yas or Nolf Yes, specify Cuban, Mexican, Puarto Rican, etc.) Funeral Was Dacedant Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, atc. 11. Merital Status 1 Nevar Married Married 1 ☐ Yes 2 € No If Yas, Giva Yaar or Datas: Baltimore, Maryland 21215-0020 1 Yas 2 No Specify Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Middle, Meidan Sumama) 17. Fathar's Name (First, Middla, Last) 's Nama (First. Be 10 AMUEL 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code, 20b. Plece of Disposition (Name of Data 20c. Location - City or Town, 20e. Mathod of Disposition cematary, cramatory or other place, 1 Buriel 2 Cramation 3 Ramoval from State
4 Donation 5 Other (Specify) MEMONIA 21. Signeture of Euheral Service Licenson 22. Name and Address of Facility Caroline 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximata tntarval Batween Onset end Deeth **Physician** Immediate Cause (Finel diseasa or condition rasulting In daath) /Medical Examiner Dua to (or as a consequanca of) Examiner that the deeth certificate be executed the burial-transit Sequentially list conditions, if any, leeding to immadiata cause. Entar Undarlying Causa (Disease or Injury that initiated events rasulting in death) Last and Due to (or as a consequence of) P.O. Box 68760. TV attending physician Physician/Medical Dua to (or as a consequence of): tor: After this certificate has been signed by the a the funeral director, page 2 should be detached to Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco uss contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ Completed 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 2 No 1 Yas 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was casa refarred to medical axaminer? 28. Piece of Deeth (Check only one) Other: 4 Nursing Homa 3 Thesidence 6 Othar (Specify) Certification: To 1 Inpatient 2DEN/Outpatient 1 Yas 2 No 3□ DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending invastigation 1-DNaturat 1 Yas 2 No 2 Accidant 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stele) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, dete end place, end due to the cause(s) and mennar as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a. Cartifiar Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatura and title of certifia (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State Registrar 32. Registrar's



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Certificate of Death Reg. No. 99
State of Maryland / Department of Health and Mental Hygiene

Physician
/Medical
Examiner

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l r	2.	ial Security 17-23	-81	03	Sex *********		7. Age (In 1 8		t birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of (Month, 07 -	Birth Day, 1	Year) -81	9. Biri	thplace ountry) M D	(State or Forei
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Director	10e. 5	Street and N	umber				•	Jul	CIMO	10f. Zip	Code				10	r. Citizen o	y What Co	ountry?	
		334 C	ott	age .	Aver	nue					1215	5				10g. Citizen of What Country? USA			
Baltimore, Maryland 21215-0020 semit. Pages 1 and 2 should be filed within 72 hours after death 1 beginnment of Heath and Mental Hygiene. mportant: if Item 27 is marked other than "natural", or items 23 ny injury or other traumate event, its Medical Examinar must nice.  To Be Completed by Funeral		erital Status Never Me	rried 2[		AI 1 If	1 ☐ Yes 2X No If Yes, Give 1 ☐ Yes 2☐				nt of Hispanic Origin? (Specify Yes or No y Cuban, Mexican, Puerto Rican, etc.)			No-		ece - Ame lack, Whit				
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	19e. Informent's Neme/Reletionship (Type, Print)  19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 4										<sub>de)</sub> 21239								
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						ral fanas G	20	Ob. Plac	e of Disponetery, crer	osition (Nam	ne of ther piec	xe)		Date	2	Oc. Location	n - City or	r Town,	Stata
				20a. Method of Disposition  1 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 Donetion 5 Other (Specify)  20c. Location - City or Town, State  Kings Mem. Pk. Cem. 107-31-99 Randallstown, Mem. Pk.											own, MI				
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Maryland 2120																		
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State Registrar

DHMH 16 Rev 6/95

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** MUHL EdNA MARIE 445 AM 99 7 26 /Medical 4e Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Rose
If Under 24 Hrs.
Min. Baltimore Square tranklin dale tal Cen 8. Date of Birth (Month, Day, Year) April 22, If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 2 □ XF 97 1902 Maryland 218-32-1952 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours efter death with the Meryland nent of Health end Mentel Hygiene.

Int: If item 27 is marked other than "natural; or items 23a or 28a-f show ary or other traumatic event, the Medical Examinations and item and the notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Baltimore 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Eastern Blvd. 21221 U.S.A. Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11 Maritel Status 1 □ Never Married 2 □ Married Yes 2 No Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: Specify: White þ 3 ☑ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Corsitier Clothing 6 18. Mother's Neme (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Richard Caldwell Mary (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marion L. Ricketts 504 Meadow Road Baltimore, Maryland 21206 mportant: If item iny injury or othe 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 7/31/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility 21. Signal John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206 Approximate Interval Between Onset end Death e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** /Medical Immediate Ceuse (Final 20 days Pheumonia disease or condition resulting in death) Examine Due to (or as a consequenca of): Examine potemia The law requires that the death certificete be executed physicien and the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): 98 for use es signed by the e 23b. Did tobacco usa contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 | Yes 2 No 3 | Probably 4 | Unknown þ 24b. Were autopsy findings evellable prior to completion of cause of deeth? should l 24a. Was an autopsy Completed s certificate hes b director, page 2 s 1 Yes 20 No 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1- Inpatient 2 □ ER/Outpatient 3 □ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? Certification: After 1-2 Neturel 5 Pending investigation 1 Yes 2 No r deeth. ector: A 2 Accident 6 Could not be determined 3 ☐ Suicide 24 hours efter de Funeral Directo letely filled in by th 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide Medical 29a. Certifier 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es stated. To the Hosp within 24 ho To the Fune completely fi 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) Wand 26 110

9000

MD

32. Registrar's Signature

Franklin Square

maryland

State Registrar Savitha

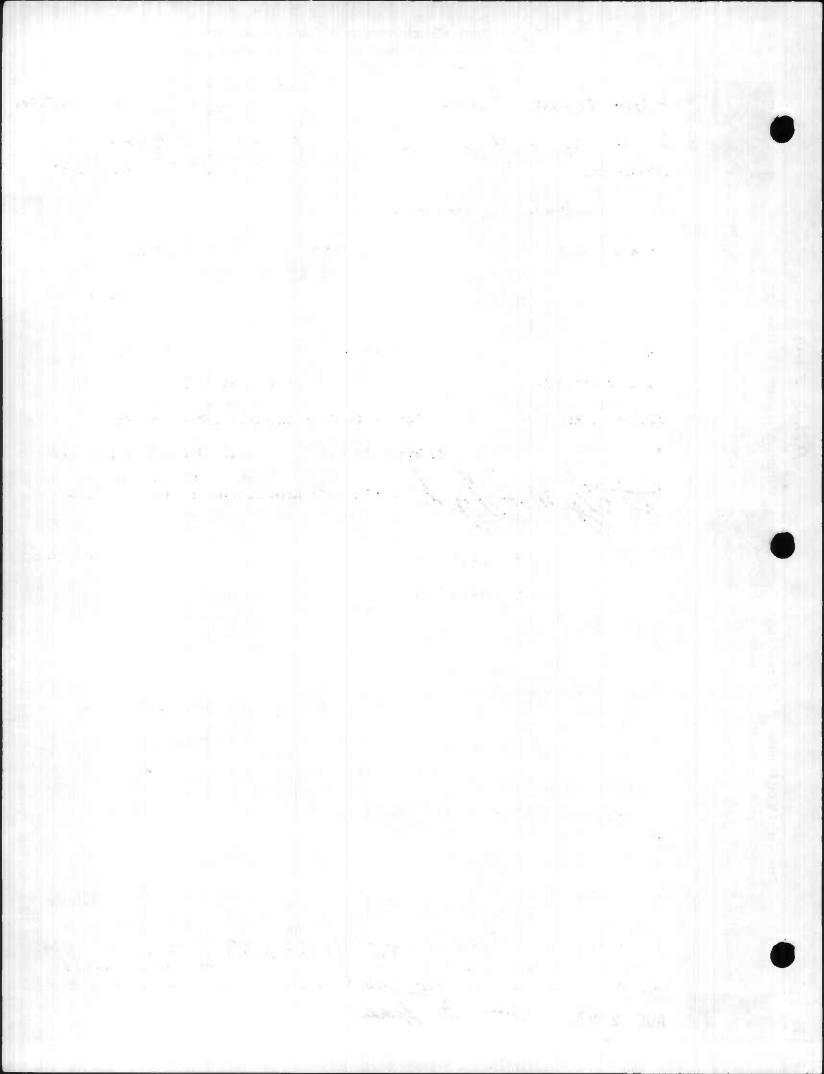
31. Date filed (Month, Dây, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shivananda

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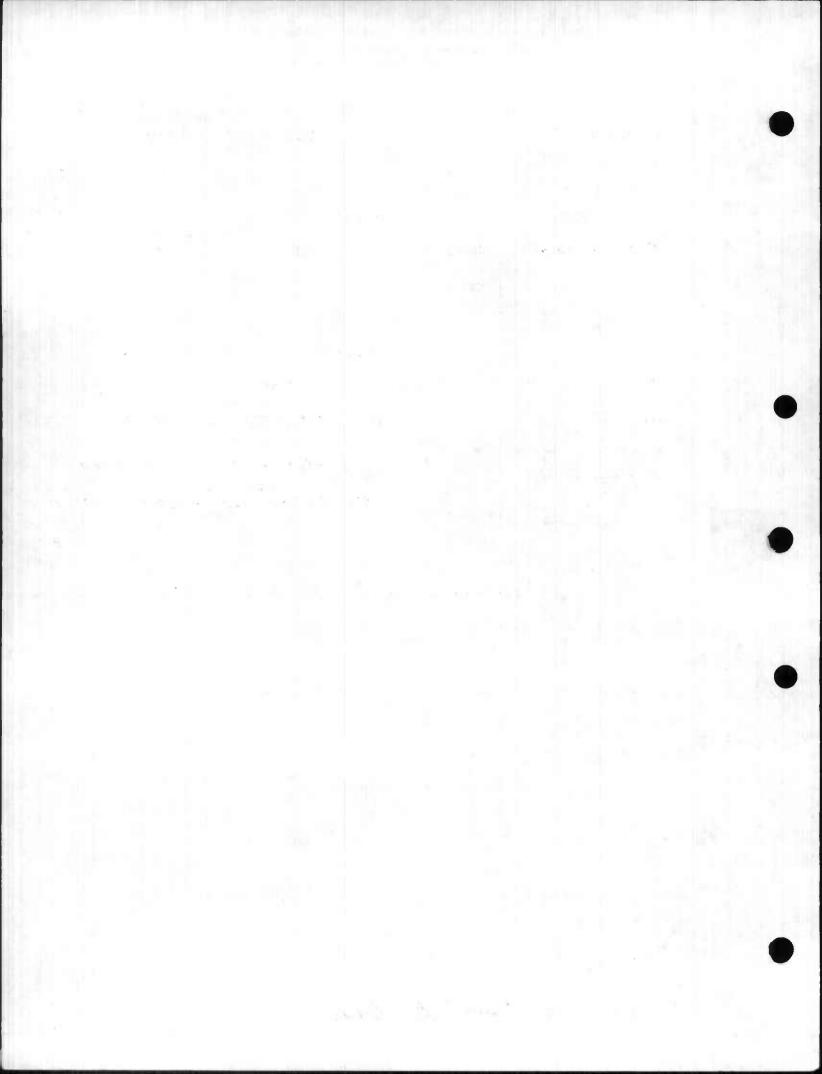


## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 4b. City, Town, or Location of Death 28 10:02 Florence 1999 ROSE /Medical 4a Facility Name (If not Institution, give street and number) 4c. County of Death Examiner NORTHWEST HOSPITAL RANDALLSTOWN BALTIMORE 5. Social Security Number 212-36-9813 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 □ M 2 🛛 F Yrs. 91 **Director** OCT.30,1907 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 23a or 28a-f show 1 ☐ Yes 2 No FL DADE Directo N. MIAMI BEACH 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2750 NE 183RD STREET #2601 33160 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married yland 21215-0020 8 1 ☐ Yes 2 No Specity: Specify: þ WHITE Pages 1 and 2 should be filed within 72 hours next of Health and Medical Hyglens. This tracked other than 7 tentural; can't if them 27 is marked other than 7 tentural; cavent, the Medical Exa. 3€ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) å HARRIS LEVETON 2 SARAH SMITH 19a. informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EDWARD ROSE / SON 2329 VELVET RIDGE DRIVE - OWINGS MILLS, MD 21117 altimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW CEMETERY 7/29/99 REISTERSTOWN, MD 21. Signeture of Funeral Service Licenson 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting In death) /Medical MYCOCOMPICI a ACUIX intenctio. Examiner Due to (or es e consequence ol): Examiner Ischamic Heart D. Jeasy The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enler Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): D. OB-Lus m-11, 1 us Physician/Medical Due to (or as a consequence of): been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Hypunlansion Records, þ 24b. Were autopsy lindings available prior to Completed 24a. Was an autopsy performed? Heary rullun. Conjustive completion of cause of death? page 2 1 Yes 2 No 1 Yes 2 No certificate Division of Vital or Amending Physician; Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Menner of Daath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Netural 24 hours after death.

Funeral Director: Al 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 3 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, Stele) 4 Homicide ni bellil Hospital 29a. Certifier 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) within 2 To the I \$ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 1 ale July 28 029085 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROOD Allun CUS COURT J -32. Registrer's Signature 31. Date filed (Month, Day, Year) State 2 1999 AUG Registrar

AHS

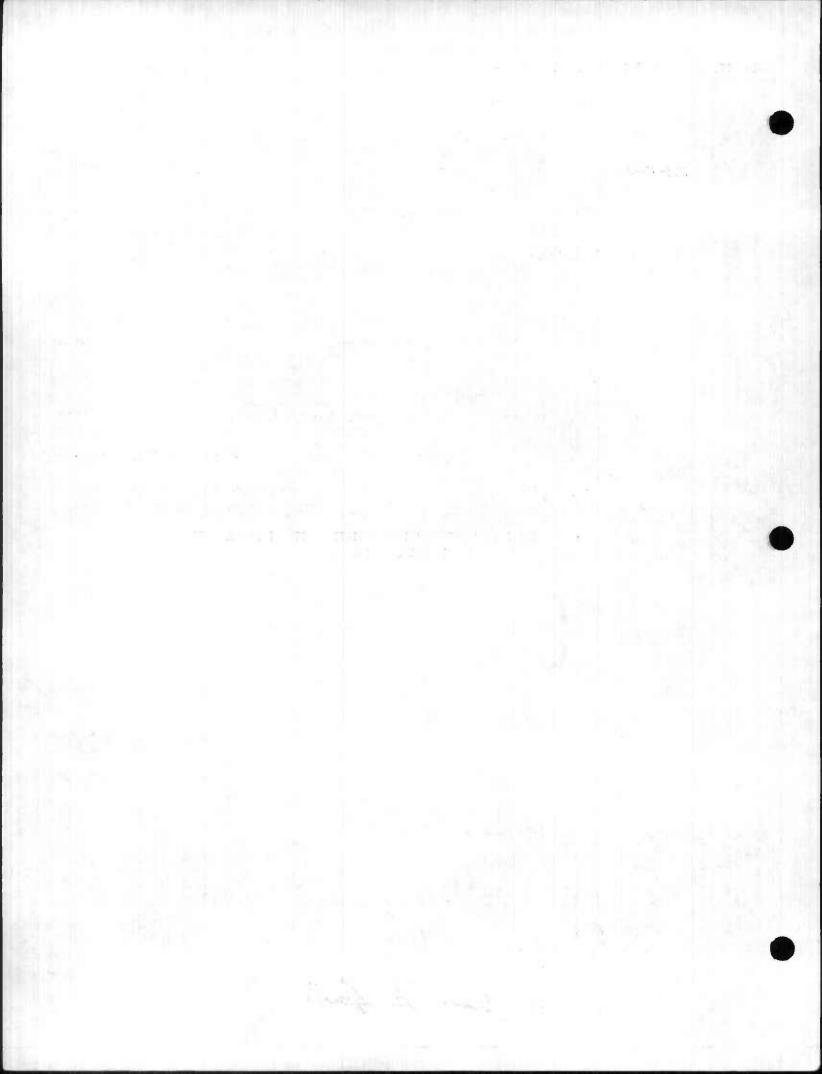


### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

BRYAN A

1. Decedant's Nama (First, Midan BRYAN ANG	ddie, Last)	RANDALL	Cer	rtificate of	Deall	2. Data of D Month JULY	Day	Yaar 1003 AM					
49 Facility Nama (If not institution SINAI HOSPIT	tion, giva street and	nu <i>mber)</i>			4b. Cify, Town, OBALTIM	or Location of Dea		ty of Deeth					
5. Social Security Number 218-78-2607	6. Sax 1 X M 2□ I	F	s. last birthday) Yrs.	If Under 1 Yeer Months Days	If Under 24 H Hours M		irth 1962	9. Birthplace (State or Foreign Country) Maryland					
Usual Rasidence of Decedant 10a. Stata 10b. Cour Md . N/A 10e. Street and Number			City, Town or Lo					10d. finsida City Limits 1  Yes 2 □ No					
	e Poed			10f. Zip Coda 21229			10g. Citizen of What Country?						
3705 Woodridge  11. Marital Status  1 Never Merried 2k M  3 Widowed 4 Divorce  15. Deced (Specify only high Elementary/Secondary (0-12)	12. Was C Armed 1 1 Ye If Yas,	Decedent Ever in d Forcas? es X No , Giva or Detes:		Wes Decedent of H If Yas, specify Cubi  ☐ Yas 2 No	lispanic Origin?	(Specify Yas or Nerto Rican, etc.)	lo- 14. Ra Bla	ios - American Indian, ack, Whita, atc.					
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17. Father's Neme (First, Middle James Randal)						lama (First, Middl es Carte	,	ma)					
19a. Informant's Name/Reletion Delores Randal			The second second	ng Address (Street Woodridg				n, State, Zip Code) 71and 21229					
		om State	camatary, cran	netory or other plea		7/30/99		- City or Town, Stata					
1/10	we z	OULLAND at caused the day	To	7illiam C	1 ☑ Buriel 2 ☐ Cramation 3 ☐ Ramoval from State camatary, crametory or other pieca)								
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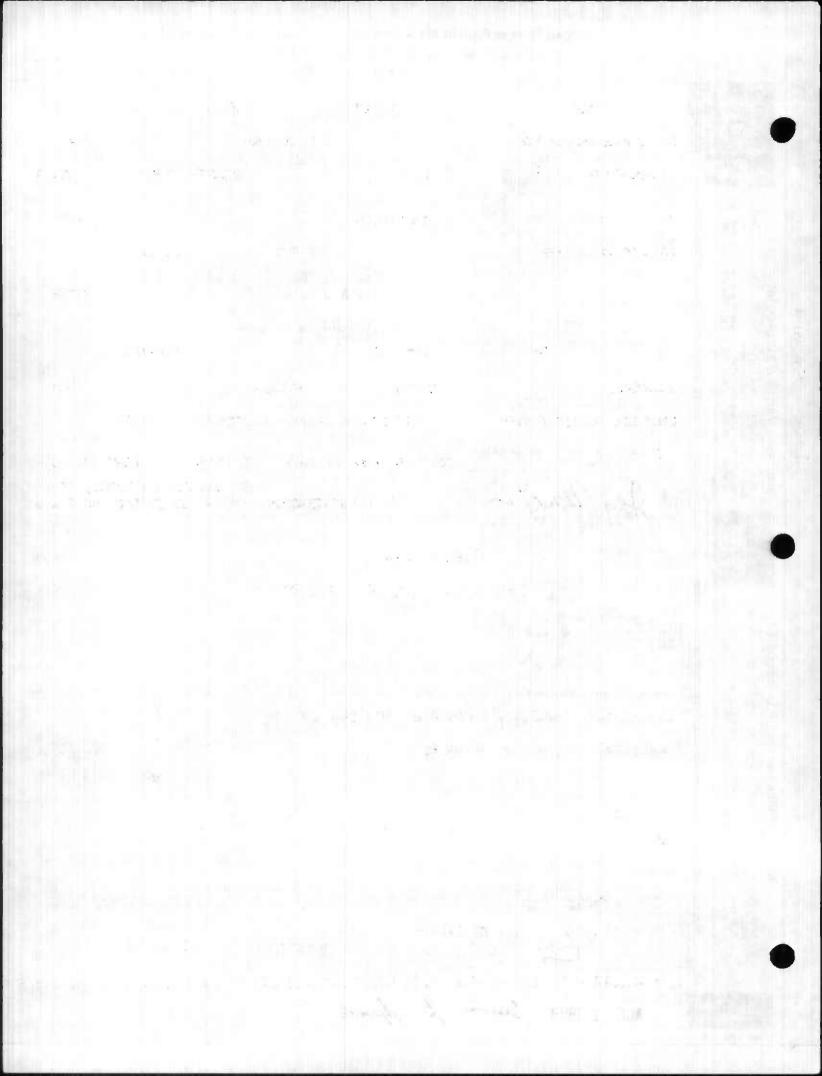
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					Ce	rtificate d	of Death		Reg. No.		
Dharai	1. Decedent's Nam	ne (First, Middla,	Last)					2. Date of De Month		Yaar	3. Time of Death
Physician /Medical		JACK			SF	OBIN		JULY		999	12.15 PM
Examiner	4a Facility Nama (						BALTIM				N/A
Funeral Director	5. Social Security 1 214–38–7	7593	5. Sax 1 ☑ M 2 ☐ F	7. Aga (In yrs.	last birthday 92 Yrs.	Months Da		Hrs. 8. Date of Bir (Month, Do. JULY 2)	th by, Year) 6, 1907	9. Birthp Cour	placa (Stata or Foraig ntry) LATVIA
ž	Usuat Residence of	10b. County		10c. Ci	ity, Town or L	ocation				1	10d. Inside City Limits
28a-f show notified at	MD	N/A			BALTI	MORE					1 N Yes 2 No
r items 23s or 25s-fs in er must be notified Funeral Director	10e. Street and Nu 2313 ROC		VE			10f. Zip Cod	21209		10g. Citizan of U.S.A		ntry?
by		ried 2 Marrie	Armed F	2 No	J,S. 13.	Was Dacedent If Yes, specify C		? (Specify Yas or No uarto Rican, atc.)	14. Rac Bla Specif	ck, White,	can Indian, etc. WHITE
nt, the Medical Exit.	(Spe		grade completed,	) (1-4or 5+)	(Give	DO NOT use re	ne during most of	working	16b. Kind of B		dustry
avant, Be C	17. Father's Name	(First, Middle, L.	ast)		1		18. Mother's	Name (First, Middle	, Me <i>ide</i> n Sumer	718)	
	SHNAYNER	3			ZALMAN	I	NECHA	MA			BLOOM
27 is	19a. Informant's N GERTRUDE							r Rural Route Numb BALTIMORE			Code)
ont: If it		*	Removal from	State	cemetery, cre	ce of Disposition (Name of netery, crematory or other place H EL MEMORIAL		7/30/99		20c. Location - City or Town, Stata  RANDALLSTOWN, N	
important: If any injury or pncs.	21. Signature of F				2	2. Name and Ad	dress of Facility		INSON &	BROS	
hysician Medical xaminer	Immediate Causa disease or conditi resulting in death)	(Finat	8.	PNEU(	hon It	quence of):		rdiac or respiratory e	,,		Approximate Interval Between Onsat and Death
a attending physician and id for use as the bunal-transit is clan/Medical Examiner	Sequentially list or if any, leeding to it cause. Enter Und Causa (Diseasa or that Initiated eveni resulting in death)	S	c.		HSCUL or as a conse	quence of):	ACCIDEN	ľ ť			
for us	Part II, Other algol	ficant condition	contributing to	leath but not res	sulting in the	underlying ceuse	given in Part I.		1.1		to the causs of death
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page 2								10	Yes 2000	1	☐ Yes 2☐ No
this certificate ral director, par : To Be Co	25. Was cese refe examiner?	rred to medical					26. Place of	Death (Check only	one)		
F Sign	1 ☐ Yes 2	(No			ER/Outpatie			ng Homa 5 ☐ Res			fy)
After fune	1 Natural 2 Accident	2 Accident Investigation M 1 Yes 2 No									
within 24 hours after deet To the Funeral Director: completaly filled in by the Medical Certifical	3 Sulcida 4 Homlcide  6 Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, efc. (Specify)  28f. Location (Street and Number or R City or Town, State)										
within 24 hours after to the Funeral Dir completely filled in Medical Cerl	29a. Certifier (Check only one)  Certifying Phyalclan: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as a control of the cause of the caus										stated. to the cause(s)
To the common of	29b. Signature and	title of certifier		TENDIN HYSICIF			D 2561	0	JULY. 2		
	30. Name and add	ress of person w	ho completed ceu	so of death (Ites	m 23a) /Type	NEST B	ELVERDE	RE AVENU	E BALTI	MORE	M) 21215

State Registrar 31. Date lited (Month, Day, Yeer) AUG 2 1999





### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

				State of N	/larylan		rtment of F tificate of		d Mental Hy	giene 99	24153	
	Physic	ian	Decedent's Name (First, Middle, Last     Grace Caroly	,	ndara				2. Date of De Month July		3. Tim f th 11:55 m	
d	/Medi Examir		4a. Facility Name (If not Institution, give	-	adaro	,		4b. City, Town,	or Location of Deat			
	Exami	iei	716 Cypress Road					Severna	Park	Anne Ar		
1	Funerai Director	Г	5. Social Security Number 6. Se 214-24-5098	x 7. A	7 1	lest <i>birthday</i> ) Yrs.	If Under 1 Year Months Daya	if Under 24 H	Ain. 8. Date of Bir (Month, Dec.	11, 1927 9.	Birthplace (State or Foreign Country) Maryland	
	pu »		Usual Residence of Decedent  10a. State 10b. County		100 Cit	y, Town or Lo	nation				101	
	Aaryla sho	5	Maryland Anne Aru	ındo1		verna					10d. Inside City Limits 1 ☐ Yes 2 ☐XNo	
	the A	Director	10e. Street and Number	inder	De	verna	10f. Zip Code			10g. Citizen of Wha		
	3a or	O	716 Cypress Road				2114	6		United St		
	death	Funeral		12. Was Deceden	t Ever in U,	S. 13. V	Vas Decedent of H	lispanic Origin?	(Specify Yea or No	- 14. Race - /	American Indian,	
)20	s 1 and 2 should be filed within 72 hours efter death with the Maryland I Heelth and Mentel Hyglene. If yether 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examerations is the notified at	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates	No		☐ Yes 2 No	Hispanic Origin? (Specify Yea or Noban, Mexican, Puerto Rican, etc.)  Specify: Signature:			White, etc. White	
9	"natural",	ted	15. Decedent'a Edu	cation		16a. Deced	ent's Usuai Occup	ation		16b. Kind of Busine	ess/Industry	
21215-0020	within 7	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4o	5+)		kind of work done	aunng most of d)	working	0 11		
	her th		12th			Home	maker	40 44-4-4-1	No	Own Hom	е	
Maryland	12 should be filed within h and Mentel Hyglene. 'is marked other than "r' raumatic event, the Med	o Be	17. Father's Name (First, Middle, Last) Henry Stanley	Chalm	ners			Maria	_	, Meiden Sumeme) nie Smi	th	
ary	shoul nd Mo mark	To	19a. Informant's Name/Relationship (Ty			19b. Mallin	g Address (Street	end Number or	Rural Route Numb	er, City or Town, Ste	te, Zip Code)	
	1 and 2 a Heelth ar em 27 is other trau		Joseph A. Spadaro/	Husband	1	716 C	ypress R	oad S	everna Pa	ark, Maryl	and 21146	
Baltimore,	of Her		20a, Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ F	20b. Place of Disposition (Name of cemetery, cremetory or other place)						20c. Location - City	or Town, Stata	
tim	tant: I		4 ☐ Donation 5 ☐ Other (Specify)		Loudon Park Cemetery					8/3/99 Baltimore, Mary		
Bal	permit. Peges 1 and Department of Heelth Important: If item 27 any injury or other to once.		21. Signature of Funeral Service Licens	000			Name and Addre		Home, Inc	2.		
	20200		Juanita C	Thom	00	41	07 Wilke	ns Aven	ue Balt:	imore, Mar	yland 21229	
	Physician		23a Part Enter the disease, or complete the	diac or respiretory a	rrest,	Approximete interval Between Onset and Death						
и	/Medical		Immediate Cause (Finel disease or condition	Mela	tati.	500-	110112	VIA CA	n/95		7 000	
п	Examiner		resulting in death)		Due to (o	r es a conseq	uence of):	379 6	1) ( ( )		7 mas.	
	pet list	nine	Immediate Cause (Fine) disease or condition resulting in death)  a. Metastatic Song) Cell Lyng Cancer  Due to (or es a consequence of):  Song Cell Lyng Carer								15 mos.	
,	death certificate be assecuted e attending physician end of for use es the buriel-trensit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.									
8760,	ysicla	dical	Cause (Disease or Injury that initiated events resulting in death) Last	3	Due to (or	r as a consequ	uence of):					
9	ing ph e es ti	63	resulting in death) Last		·		·					
Вох	leath certific attending p	Physician/M		J								
o.	that the dended by the a	yslc	Part II. Other algnificant conditions con	ntributing to death	but not resu	ulting In the un	derlying cause giv	en in Part I.		oute to the cause of death?		
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Records,	v requires that been signed b should be dete								24e. Was	an autopsy 2-	tb. Were autopsy findings available prior to	
3ec	aw 2 s b	Completed									completion of cause of death?	
	F se S		W						10	Yea 2 PNo	1 ☐ Yes 2 ☐ No	
Vital		o Be	25. Was case referred to medical examiner?	lospitel:	iont 0 🗆	ED/Outpotion	3□ DOA Oth	or.	Death (Check only	one) dence 6 □Other (	Proceedings	
1 of	등 등 등	<del> </del>	27. Menney of Death	28a. Dete of In	jury	28b. Time of	28c. Injur			how injury occurred	эр <del>е</del> спу)	
Ö	Attending or death. ector: After by the fune	atio	1 ☑ Natural 5 ☐ Pending investigation	(Month, D	ey rear)	Injury		Yes 2 □ No				
Division	or Attendence of Director in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of In building, e	njury - At ho	ome, farm, stre	et, factory, office			Street end Number o wn, State)	r Rural Route Number,	
	pital ours a prai D		200 Contillor	11 - 7 - 1 - 1 -								
	1 Matural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined 2. Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  29e. Certifler (Check only one)  29e. Certifler (Check only one)  29e. Signature ap of the certifier 2 Medical Examiner: On the besis of examination and/or investigation, in my of and manner stated.  29e. License						ne, dete and pi pinion, death o	ace, and due to the courred at the time,	date and place, and	r as stated. due to the cause(s)		
	To the Within 2 To the comple	and manner stated.  29c. License number						_ ,	29d. Date signed (M	Ionth, Dey, Year)		
			Misself	11/1	e/u	will		1315	7/	Augus	+21999	
			30. Name and address of person who ed	empleted cause of	deeth (Item	23a) (Type, F	Print)	11. 1	1 (1	102 11	1 117/21	
			31. Date filed (Month, Dey, Yeer)	Clen!	10 /	640	E [ 919	Myhn	my J414	c 60 404e	19017 for 106/	
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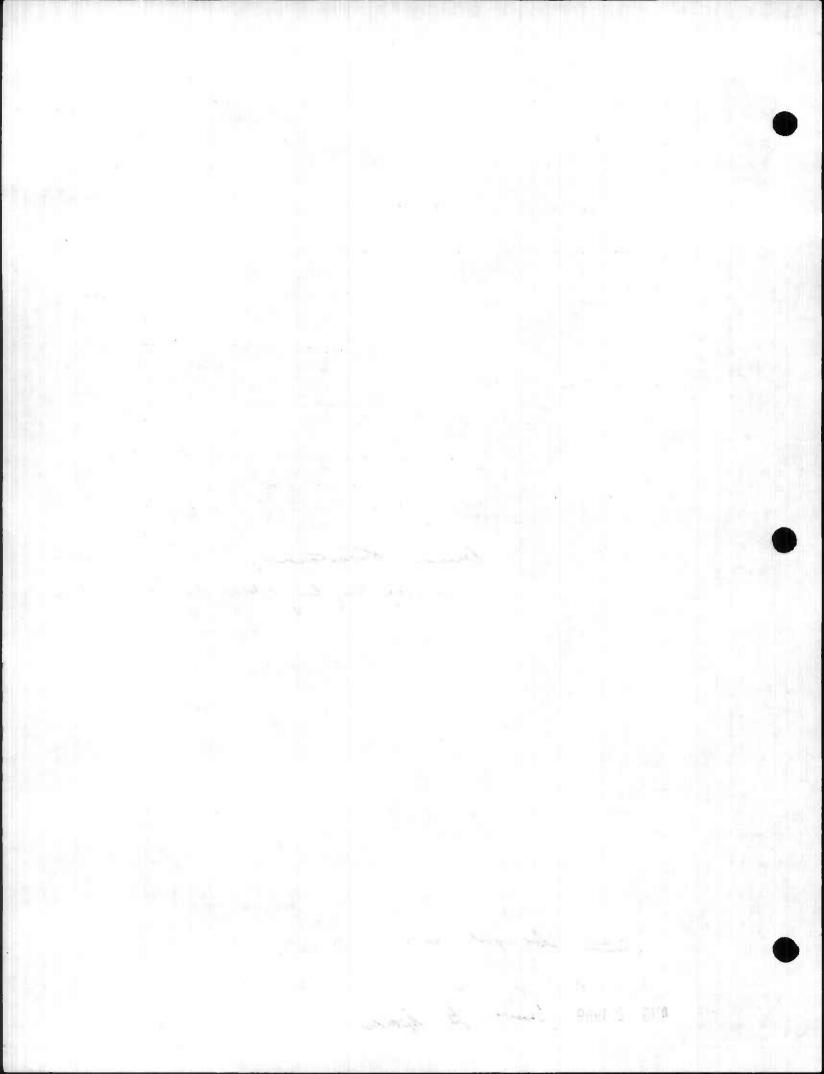
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Month Day Yaar **Physician** EMORY WINFIELD SATTERFIELD JULY 29 1999 9:15 A.M. /Medical 4b. City, Town, or Location of Death 4a Facility Nama (if not institution, give street and number) 4c. County of Death Examiner 1101 IVYWOOD LANE BALTIMORE TOWSON If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Data of Birth (Month, Dey, Year) 6/27/34 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (Stete or Foreign Country) **Funeral** Months 1X M 2 ☐ F 214-22-2058 Yes 65 Director MARYLAND Usual Rasidanca of Decedent 10b. County 10a. Stata 10c. City, Town or Location 10d. Insida City Limits BALTIMORE TOWSON MD 1 Yas 2 No Director Name 23a or 28a-f 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1101 IVYWOOD LANE APT. 201 21286 USA Funeral 14. Race - American Indian, Black, Whita, atc. 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) hours after 1 Nevar Married 2X Married 1 ☐ Yas 2 🔀 No If Yas, Giva 21215-0020 b 1 ☐ Yes 2 No Specify: Specify: ğ WHITE 3 Widowed 4 Divorced Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry filed within 72 Hygiene. Elamantary/Secondary (0-12) 12th GRADE Collega (1-4or 5+) INVENTORY CONTROL SUPERVISOR HOWARD JOHNSON aftimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mothar's Nema (First, Middle, Maiden Surneme) is merked of Be 8 EMORY WINFIELD SATTERFIELD GERALDINE FRANCES COLE Pages 1 and 2 should 19a, Informant's Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a important: if Item 27 is any Injury or other trau SON 16 STABAME COURT BALTIMORE, MD 21234 PAUL W. SATTERFIELD, JR. 20b. Plece of Disposition (Name of 20c. Location - City or Town, Stata 20a. Mathod of Disposition cemetery, crematory or other place) 1 ☑ Burlal 2 ☐ Cramation 3 ☐ Removal from Stata 8/2/99 MORELAND MEMORIAL PARK HILLENDALE, MD 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Sarvice Licensee 22. Nama and Address of Facility THE JOHNSON FUNERAL HOME, P.A. N. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, or heart failure. List only one cause or each line. Approximata Intarval Batween Onset and Death **Physician** /Medical Immediata Causa (Final disaasa or conditior rasulting in death) Examiner Dua to (or es e consequence of) Examiner The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate causa. Entar Undarlying Ceuse (Diseasa or Injury that initiated avents resulting in death) Last pue Box 68760, physician Physician/Medicai tha Dua to (or as a consequence of): 980 signed by the et d be deteched for Part II. Other significant conditions contributing to death but not rasulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? of Vital Records, P.O. 1 1 2 168 2 No 3 Probably 4 Unknown þ 24b. Ware autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? Completed peed hes page 2 this certificate 1 Yas 2 No 1 Yas 2 No 25. Was case rafarred to medical axaminar? Be 26. Placa of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Aasidenca 6 Othar (Specify) Certification: To 1 Yas 2 10 uneral 27. Manner of Death 1 Netural 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28c. Injury at Work? After Division ours effer dea. Attending 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be datarmined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28a. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicida Hospital 24 hours 6 To the Hospital within 24 hours To the Funeral I 1 Certifying Physician: To tha best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner as stated.
2 Medical Examiner: On tha basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) 29b. Signatura and title of certifian 29c. License number 29d. Data signed (Month, Day, Year) Serped up 30. Nama and address of person who complated cause of death (Item 23a) (Type, Print) ST Jes and Car Je 216 p. ck ND

State Registrar

31. Data filed (Month, Dev. Year) 2 AUG 1999

32. Registrar's Signatura



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 3. Time of Deeth 2. Date of Death 625 Day HENRIETTA **Physician** DOLLY SPRINGER July 30 /Medical 4b. City, Town, or Location of Beath 4c. County of Deeth 4a Facility Neme (If not institution, giva street end number) GENESIS ELDERCARE Baltimore Caton manore City 7. Aga (In yrs. last birthday) If Under 1 Yaar | If Undar 24 Hrs. Birthplece (State or Foreign Country) 5. Sociel Security Number Months Days Hours 1 M ACKE Yrs 96 213-10-5245 11-14-1902 MARYLAND Usual Rasidance of Decedant 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits MD BALTIMORE BALTIMORE 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 1450 KIRKWOOD ROAD 21207 U.S.A. Funeral 12. Was Dacedant Evar In U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. I ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried 1 ☐ Yes 2 No Specify: Specify: WHITE à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) RECEPTIONIST 18. Mother's Neme (First, Middle, Maiden Sumame) STEWART COMPANY 12 17. Fether's Neme (First, Middle, Last) Be JACK SPRINGER MARTHA (HICKMAN) 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) DOROTHY KEMPLE 1450 KIRKWOOD ROAD (NIECE) BALTIMORE, MD 21207 20b. Plece of Disposition (Neme of cemetary, cremetory or othar pleca) 20e. Method of Disposition 20c. Location - City or Town, Stete Buriel 2 Crametion 3 Removal from Stete 4 Donetion 5 Other (Specify) OUDON PARK CEMETERY 8/2/99 BALTIMORE, MD 22. Nama end Address of Fecility WITZKE FUNERAL HOMES, INC. 1630 EDMONDSON AVE CATONSVILLE, MD aused the daath. Do not enter tha mode of dying, such es cardiec or respiretory errest, Approximete Intervel Between Onset end Deeth Enter the disease, of complications that caused to shock, or haert failure. List only one ceuse on each line Immediate Cause (Final disease or condition resulting in deeth) Examiner Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Diseese or Injury thet Initiated avents resulting in death) Last Due to (or es e consequence of): Physician/Medical Dua to (or as a consequance of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings evailable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed 1 Yes 2 No 25. Was case referred to medicat Be 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 No To Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of 27. Menner of Deeth 28c. Injury et Work? Certification: 1 Netural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. edicai Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and memors stated. Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and memor stated.

Division of Vital or Attending

P.O. Box 68760.

Registrar

Examiner

**Funeral** 

**Director** 

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Mantal Mental

marked

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**Physician** 

/Medical Examiner

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After

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Hospital 24 hours

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29b. Signeture and title of certifier

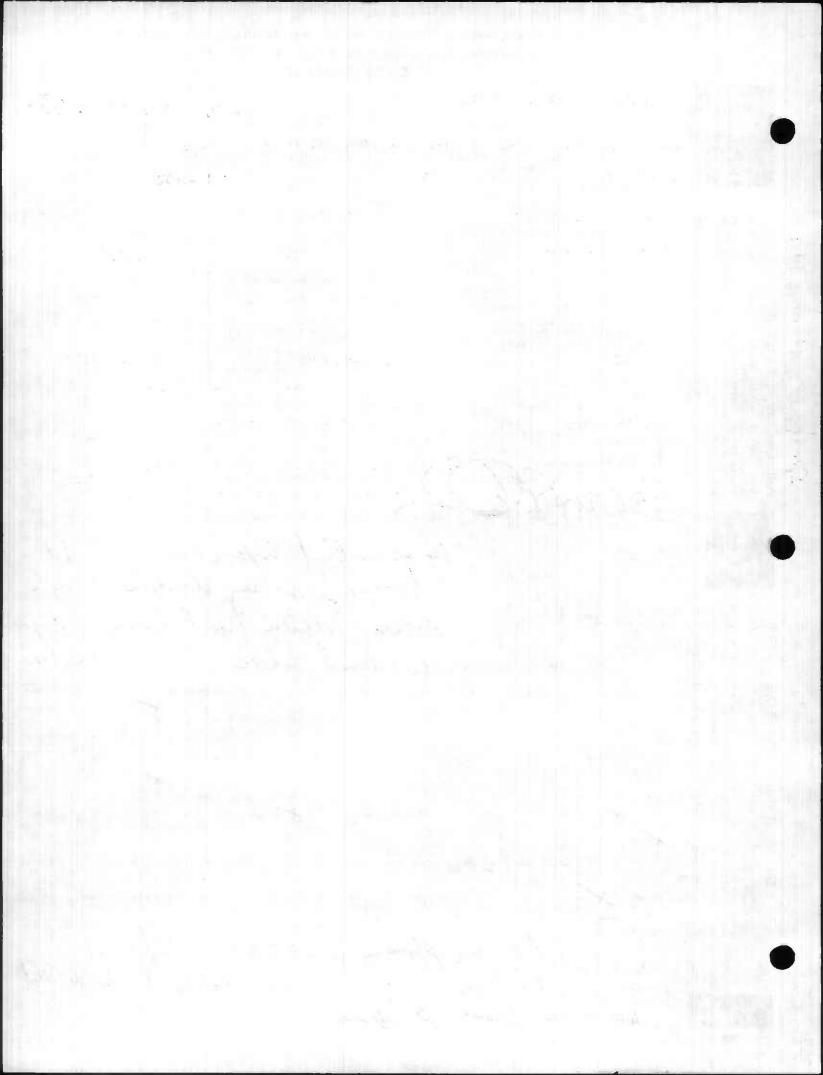
(Check only

one)

30. Name and eddress of person who completed cause of death (Vem 23e) (Type, Print) INsvence

32. Registrer's Signeture

29c. Licanse number



### Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

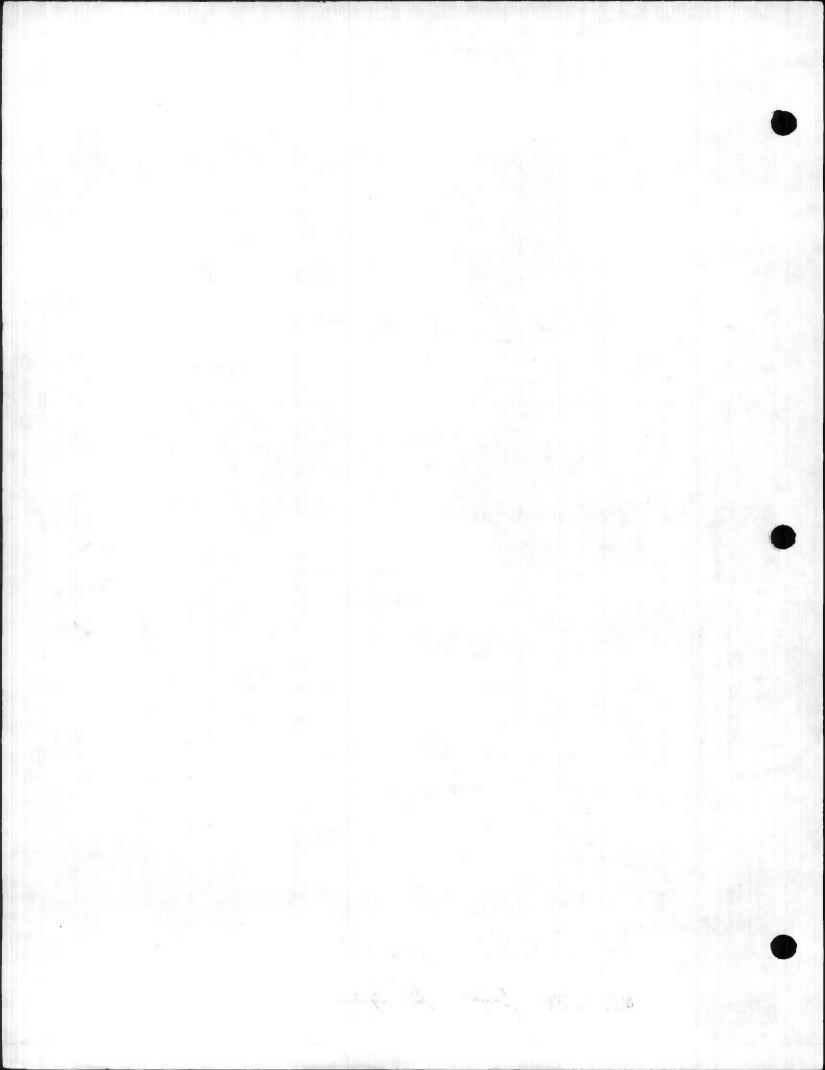
State of Maryland / Department of Health and Mental Hygiene 99 21, 156

			Ce	ertificate	of Death		Reg. No.			
Discordadas	1. Decedent's Name (First, Middle, I	ast)				2. Date of Month	Death	Voor	3. Time of Death	
Physician /Medical	Catherine		Sunder1	and		Augus	st 1, 1	999 Year	9:30PM	
Examiner	4a Facility Name (If not institution, g Millennium Hea		2 ° - 2 c		Glen	n, or Location of De Burnie	eath 4c. Co	ounty of Death		
Funeral Director	5. Social Security Number  214-12-1844  Usuat Residence of Decedent	- Die erve	e (In yrs. last birthda) 37 Yrs.		ear If Under 2 ays Hours	Min. 8. Date of (Month, Sept.	Birth Zear 19	9. Birth	nplace (State or Foreig Pyland	
Pand Mand	10a. Stete 10b. County		10c. City, Town or I	ocation				T	10d. Inside City Limit	
s after death with the Menylan or items 23a or 28s-f ahow in her mart be notified at y Funeral Director	Maryland N/A		Baltimo	re 10f. Zip Co	do		100 0200	on of What Cou	1 Yes 2 No	
ath with 23a or with bearing the real Directory	1232 Cleveland			212	30		USA			
72 hours after death with the Meryland natural; or flems 23a or 28s-f show deal Examiner must be notified at steed by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Merried  3 □ Widowed 4 ☑ Divorced	12. Wes Decedent Armed Forces? 1  Yes 2 I		Was Decedent If Yes, specify  1 ☐ Yes 2 ☒		ban, Mexican, Puerto Rican, etc.)  Specify:		Black, White		
72 h	15. Decedent's (Specify only highest of		16a. Dec	edent's Usual O	ccupation one during most ( etired)	of working	16b. Kind	of Business/In	ndustry	
led within 72 ho ygiene. Nor than "natura it, fre Weder! Completed	Elementary/Secondary (0-12)	College (1-4or	0+1	Compan			Ret	ail Ma	nufacturin	
2 should be filed within 72 hours and Mental Hygiene. Is marked other than "natural; raumatic event, in Medical Extra To Be Completed by	17. Father's Name (First, Middle, Las Sam	venturall	a		18. Mother Santa	s Name (First, Mide	unkno			
alth and N 27 is mer or traumed	19a. Informant's Name/Reletionship Marie Noonan	(Type. Print) daughter	19b. Mai 8472	ing Address (S Main A	reet and Number ve. Pasa	or Aural Aoute Num dena, Mar	nber, City or 1 ryland	Town, State, Zi 21122	ip Code)	
permit. Peges 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: if item 27 is marked other than any injury or other traumatic event, the Mance.  To Be Comp	20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremetion 3  4 ☐ Donation 5 ☐ Other (Special Control of			position (Name of the Crematory or other	place)	8/2/199		ition - City or T	Maryland	
Departi Departi Importi any inj	21. Signature of Funeral Service Lio	e P.A. sadena, MD 21122								
	23a. Part1. Enter the disease, or co- shock, or heart failure. List onl	nplications that caused	the death. Do not e					1	Approximete Intervel Between	
Physician					Onset and Deeth					
/Medical   Examiner	Immediete Cause (Final disease or condition	Cor	onary Ar	tery D	isease				1 year	
	resulting in death)	d	Due to (or as a consequence of):							
axecuted an and rel-transit Examiner	Essential Hypertension 10 years									
and I-tran										
buria buria	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c. Cer	ebrovasc	ular A	ccident	t	5		5 years	
erificate be associted ling physician and se as the burial-transit Medical Examin	that initiated events resulting in death) Last		Due to (or as a consequence of):							
seth certificate be assecuted attending physicien and for use as the buriel-transit clary/Medical Examir		Sen	ile Deme	Dementia					6 years	
death ed for u	B					1		-		
that the death cert ed by the attendin detached for use y Physician/N	Part II. Other significant conditions	contributing to death b		id tobacco us		to the cause of death obably 4 Unknow				
been sign should be							as an autopsy erformed?	a c	Were eutopsy findings iveilable prior to completion of cause of death?	
The law ate has bege 2 s						11	☐Yes 2反		☐Yes 2☐ No	
ysician: The list certificate he director, pege	25. Was case referred to medical				26 Place o	of Death (Check on			5.00 25.00	
Physician: this certific ral director. TO Be (	examiner? 1 ☐ Yes 2 ☑ No	Hospitat:	nt 2 ER/Outpatio	ent 3 DOA	Other	sing Home 5 🗆 Re		☐Other (Spec	eitv)	
는 토로	27. Manner of Death	28a. Date of Inju (Month, Da	ry 28b. Time				e how injury			
To the Hospital or Attending Physician 24 hours after death.  To the Funeral Director: After the completely filled in by the funeral Medical Certification:	1 Natural 5 Pending 2 Accident investigativ 3 Suicide 6 Could not determine	on 28e. Place of Inj	28a. Date of Injury (Month, Day Year)  28b. Time of Injury M  28c. Injury at Work? 1 □ Yes 2 □ No  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To the Hospital or Att within 24 hours sited To the Funeral Diract completely filled in by Medical Certifi	29a. Certifier 15 Certifying P (Check only 2 Medical Exa	hysician: To the best of miner: On the basis of and manner sta	examination and/or i	th occurred at ti	ne time, date and my opinion, death	place, and due to to occurred at the time	he cause(s) er	nd manner as lace, end due	stated. to the cause(s)	
Me the	290. Signature and title of certifier	A A		29c, Li	cense number		29d. Date	signed (Month	Day Year)	
A Non	· Hay	Jugh	_ M-		D14160			1.2,19	1117	
	30. Name and address of person who	completed cause of d	eath (Item 23a) (Type	, Print)						
	Harjit Singh	M.D. 5	410=A Ri	Echie	Highway	Z Raltim	ore	Md. 21	1225	
State	31. Date filed (Appring Day, 2 ar) 19	39 32 1999	410=A Ri	sport			0101	LICE		

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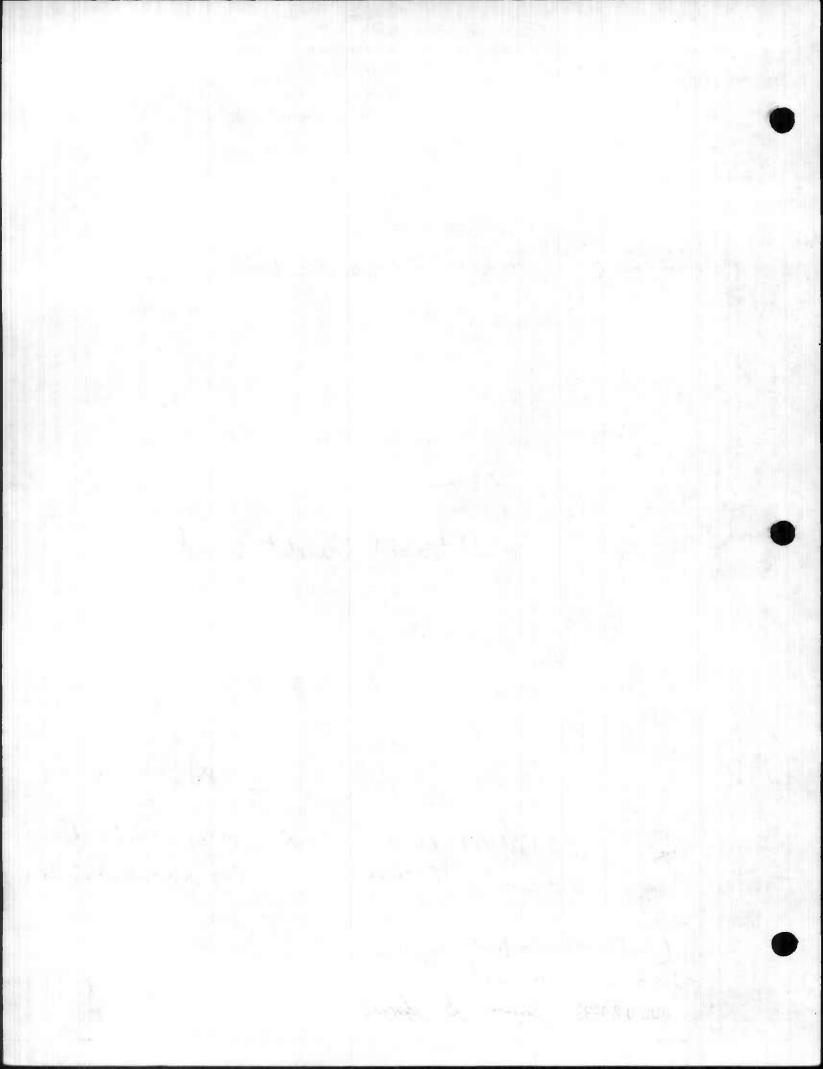
Registrar



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 21.157

		Certificate of Death	Reg. No.	24191		
	Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death		
Physician	Andre Swann		July 28, 1999	1:11 P.M.		
/Medica Examine	As Essitiv Name (Mant in this time also stand as described)	4b. City, Town, or	r Location of Death 4c. County of D			
Examine	University of Maryland, Shock Tra	uma Baltin	more N/A			
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last bit	irthday) If Under 1 Year   If Under 24 Hrs	s. 8. Date of Birth 9.1	Birthplace (State or Foreign		
Director	214-88-5545 1⊠ M 2□ F 37  Usual Residence of Decedent	Yrs. Months Days Hours Min	Dec 21, 1961 MD	Country)		
The Maryland 28a-f show soffled at	10a. State 10b. County 10c. City, Tow	vn or Location		10d. Inside City Limits		
Man Man	MD N/A Balti	more		1¥ Yes 2 □ No		
or 28a-t s be notified	10e. Street and Number	10f. Zip Code	10g. Citizen of What	10g. Citizen of What Country?		
ag a co		21201	United St	ates		
ther death of the format the form	11. Marital Status 12. Was Decedent Ever in U,S.	13. Was Decedent of Hispanic Origin? (		merican Indian,		
THE PERSON	3 ☐ Widowed 4 ☐ Divorced	If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 No Specify:	rto Rican, etc.)  Specify: Black			
od within 72 ho yglene. wer than 'neturn it, the Medical.	15. Decedent's Education 16a	. Decedent's Usual Occupation	16b. Kind of Busine	ss/Industry		
Zum min	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of wo life. DO NOT use retired)	Departmen	nt of		
A ADP	12 L.	aborer	Sanatatio	on		
Ind 2 tal Hygi d other event, if	17. Father's Neme (First, Middle, Last)	18. Mother's Na	ame (First, Middle, Maiden Sumame)			
Viar Menta Menta Menta Menta Mic en	Clarence P. Swann	Margie	Marie Sampson			
a de la		b. Mailing Address (Street and Number or F	Rural Route Number, City or Town, Stat	e, Zip Code)		
C 72 PK No	Mrs. Margie Gagum (Mother) 8	49 West Lombard Stre	eet, Baltimore, MD	21201		
Ore, Note and of Health (New 27 rother tr	comete	of Disposition (Name of ery, crematory or other place)	Date 20c. Location - City	or Town, State		
Pag ment it	1 La-Bunat 2 Li Cremation 3 Li Hemoval from State	imore Cemetery  22. Name and Address of Facility	Aug 3 1999 Baltimore	e., MD		
Demit Depart Import any in	aloun L. M. Survey	Funeral Home, P.F ore Street Baltim	Baltimore, MD			
	23a. Part T. Enter the disease, or complications that caused the death. Do shock, or heert fellure. List only one ceuse on each line.	not enter the mode of dying, such as cardie	ac or respiratory arrest,	Approximate Intervel Between		
Physician /Medical Examiner		Lovel Grandet	- Wourd	Onset and Death		
DOX OCIOU, attractificate be executed attending physician and for use as the bunal-transit		consequence of):				
death death ad for u	Part II. Other eignificant conditions contributing to death but not resulting	in the underlying cause given in Pert I.	23b. Did tobacco use contrib	23b. Did tobacco use contribute to the cause of death		
d by the letach				Probably 4 Unknown		
requiper should			24a. Was an autopsy performed?	tb. Were autopsy findings available prior to completion of cause of death?		
The lay			Yes 2□ No	1 No Yes 2□ No		
vital The certificate rector, page Co	25 Was case referred to medical	26. Place of Dr	eeth (Check only one)	/		
Physician: this certific ral director,	examiner?  1 ☑ Yes 2 ☐ No  Hospital: 1 ☐ Inpatient ②□XER/O	Other:	Home 5 ☐ Residence 8 ☐ Other (5	Specify)		
Attending Physical Control Con		Time of Injury at Work?	28d. Describe how injury occurred	tself		
2 2 4 2 5	Suicide 6 Could not be determined 25e Place of Injury - At home, for the pulking, etc. (Specify)	arm, street, factory, office	281. Location (Street and Number or Rural Route Num City or Town, State)			
To the Hospital within 24 hours of To the Funeral Completely filled	28a Certify 1 ☐ Certifying Physician: To the best of my knowledge 2 ☐ Medical Examiner: On the basis of examination and manner stated.					
within 2 To the comple	29b. Signature and title of certifier	29c. License number	29d. Date signed (M	fonth, Day, Year)		
- s - o	I My tol and	O.C.M.E.	מכ עזווד	1999		
	20 Now and address of account of the control of the		JULY 29,	エフラフ		
	30. Name and address of person who completed cause of death (Item 23a)		Baltimore, Marylan	nd 21201		
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signeture	Sported				



DHMH 16 Rev 6/95

To the

Hospital or Attending Physician: The law requires that the death certificate be executed

68760

Box (

P.O. 1

Records,

Division of Vital

aitimore. Maryland 21215-0020

State Registrar LUIS

31. Dete filed (Month, Dey, Year) 2 1999

DIAZ

32. Registrer's Signeture

JOHNS

30. Name and address of person who completed cause of death (Itam 23a) (Type, Print)

MD

KES - 000

HOSPITAL

July 26, Figg

BALTIMORE

**ORIGINAL** 

HOPKINS

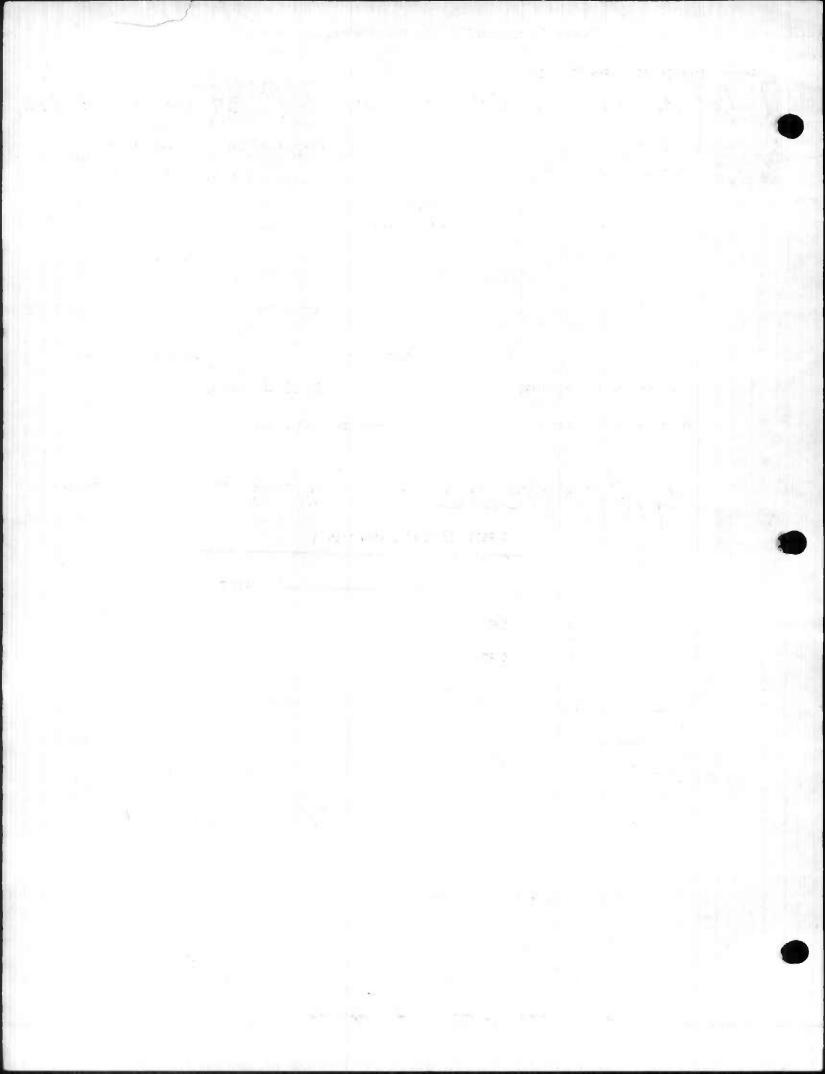


# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended Item#23apt1 perPhyG774 8/2/99 EW Decedant's Neme (First, Middle, Last) 2. Date of Deeth Time of Deeth OUDWARD SHELTON **Physician** :10 AM /Medical 4a. Fecility Name (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** | Cockeysville |
| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) Broadmeade Baltimore 5. Sociei Security Number 7. Age (In yrs. lest birthday) **Funeral**  Birthplace (State or Foreign Country) Deys Months 1⊠M 2□ F 87 Vre Director 149-01-4596 May 5, 1912 Mass. Usual Residence of Decadent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits 28a-f show d 2 should be filed within 72 hours after death with the Maryla. It and Mental Hygiens. The marked other than "natural", or items 23a or 28a-f show traumsite event, the Medical Examinate must be notified at 1 ☐ Yes 2 No Director Baltimore Maryland Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 13801 York Road 21030 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 11. Maritel Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American indien, Btack, White, etc. 1 ☐ Never Merried 2 ☐ Married l □ Yes 2√ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2√ No Specify: þ Specify: white 3 ☐ Widowed 4 ➡ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Librarian Community College 17. Father's Name (First, Middla, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Joseph Donald Woodward Harriett Breisch 19a. Informant's Name/Relationship (Type, Print) 19b. Maiting Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: if hem 27 is
any injury or other trau 5715 Edmondson Ave. #AA7, Baltimore, MD Richard Shelton/son 21228 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20a, Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 Donation 5 Other (Specify) 21. Signature of Funger Service Licensee 22. Name and Address of Fecility State Anatomy Board, Ronald Sa Director 655 W. Baltimore Street ale 16000 Baltimore, MD 21201 Part I. Entar the disease, or complications that causad tha daath. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Intervet Batween Onset and Deeth Physician 20 Bowel obstruction SEPSIS, /Medical Immediate Cause (Final mo disease or condition resulting in death) Examiner ASCVD Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or es a consequenca of) Box 68760, CHF 2 Physician/Medical that the death certificate Due to (or as e consequança of): COPD Pert li. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contributa to the cause of death? Division of Vital Records, P.O. à 1 ☐ Yee 2 ☑ No 3 ☐ Probably 4 ☐ Unknown peudis À The law requires 24b. Wara autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? Completed 2 No 1 ☐ Yes 2 ☐ No Attending Physician: certific 25. Was case referred to medical examinar? Be 26. Placa of Death (Check only one) 2 1 Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Pile B 28a. Date of injury (Month, Dey Year) 28c. injury at Work? 27. Manner of Death 28b. Tima of 28d. Describe how injury occurred Certification: Attar 5 Pending 1 Naturel death investigation 1 □ Yes 2 □ No 2 Accident or Attend after death Director: / 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicida 28e. Plece of injury - At home, farm, street, factory, office building, etc. (Specify) à 4 Homicide To the Hospital or within 24 hours at To the Funeral Di completely filled in 29e. Certifier Certifying Physicien: To the bast of my knowledge, death occurred at the time, data and place, and dua to the cause(s) and manner as steted. Medical (Check only 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and manner stated. 29b. Signature andtitlejóf certifie 29d. Dete signed (Month, Dey, Year) d cause of death (Itam 23a) (Type, Print) COCKERSVILLEMA 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State

DHMH 16 Rav 6/95

Registrar



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth

1. Decedent's Name (First, Middle, Lest) 3. Time of Death Month JULY **Physician** Dey 26 1999 Alexander Arthur Szymanski 1118 AM /Medicai 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Saint Joseph Medical Center Towson Baltimore 8. Dete of Birth (Month, Day, Year) July 11, 1927 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 XM 2 □ F 216-20-3972 72 Maryland Yrs Director Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at MD Baltimore Baltimore Director 1 ☐ Yes 2 No the 10g. Citizen of Whel Country? 10e. Street end Number 10f. Zip Code 21234 6 1734 Wycliffe Road Herna 23a Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status 14. Race - American Indien, of filed within 72 hours after de Hygiene. Black, White, etc. 1 Never Married 2 Married 1 ZYes 2 ☐ No If Yes, Give Yeer or Dates: Specify: White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Eiementery/Secondary (0-12) College (1-4or 5+) Supervisor Martin Pages 1 and 2 should be filed nent of Health and Mental Hygi-nt: If item 27 is marked other 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Alex Szymanski Michaline Ruszkiewicz 19e. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2. Department of Health at important: If Item 27 is any injury or other trau Dolores Szymanski 1734 Wycliffe Road Baltimore, Maryland 21234 20e. Method of Disposition 20b. Piece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 7/30/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Moreland Memorial Park 22. Name end Address of Fecility John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206 of the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, Approximete Intervai Between Onset end Death **Physician** /Medicai Immediate Ceuse (Finel diseese or condition resulting In death) CARDIO RESPIRATORY ARREST 2 MONTHS **Examiner** Due to (or es e consequence of): Examiner ACUTE INTESTINAL ISCHEMIA 2 MONTHS The law requires that the death certificate be executed physician and the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Box 68760. RUPTURED ABDOMINAL AORTIC ANEURYSM 2 MONTHS Physician/Medical Due to (or as e consequence of): for use as P.O. detached Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed l ARTERIOSCLEROTIC HEART DISEASE Division of Vital Records, þ 24b. Were autopsy findings eveilable prior to completion of cause of deeth? Completed 24e. Was en eutopsy peen PERIPHERAL VASCULAR DISEASE performed' page 2 s certificata 2 No 1 □ Yes 2 No 1 ☐ Yes i or Attending Physician: after death. Director: After this certifice 25. Wes case referred to medicel exeminer? Be 26. Plece of Deeth (Check only one) Hospitel: 1 Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpetient 3 DOA Menner of Deeth funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending 2 Accident 1 Tes 2 No investigation 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 4 Homicide

To the Hospital or within 24 hours afte To the Funeral Dir completely filled in

	(Check only one)	Medicel Examiner	<ul> <li>On the basis of exeminetion end/or investigend manner stated.</li> </ul>	etion, in my opinion, deeth occurred at the time	e, date end place, end due to the ceuse(s)
96.	Signature and	the of ceptition		29c. License number	29d. Date signed (Month, Dey, Year)
	//	112 16	12hot	D 29579	7/21/69

30. Neme and eddress of person who completed cruse of deeth (Item 23e) (Type, Print)

KOE 200 COLDSPRING LANE BALTIMORE MARYLAND 21204 WILLIAM

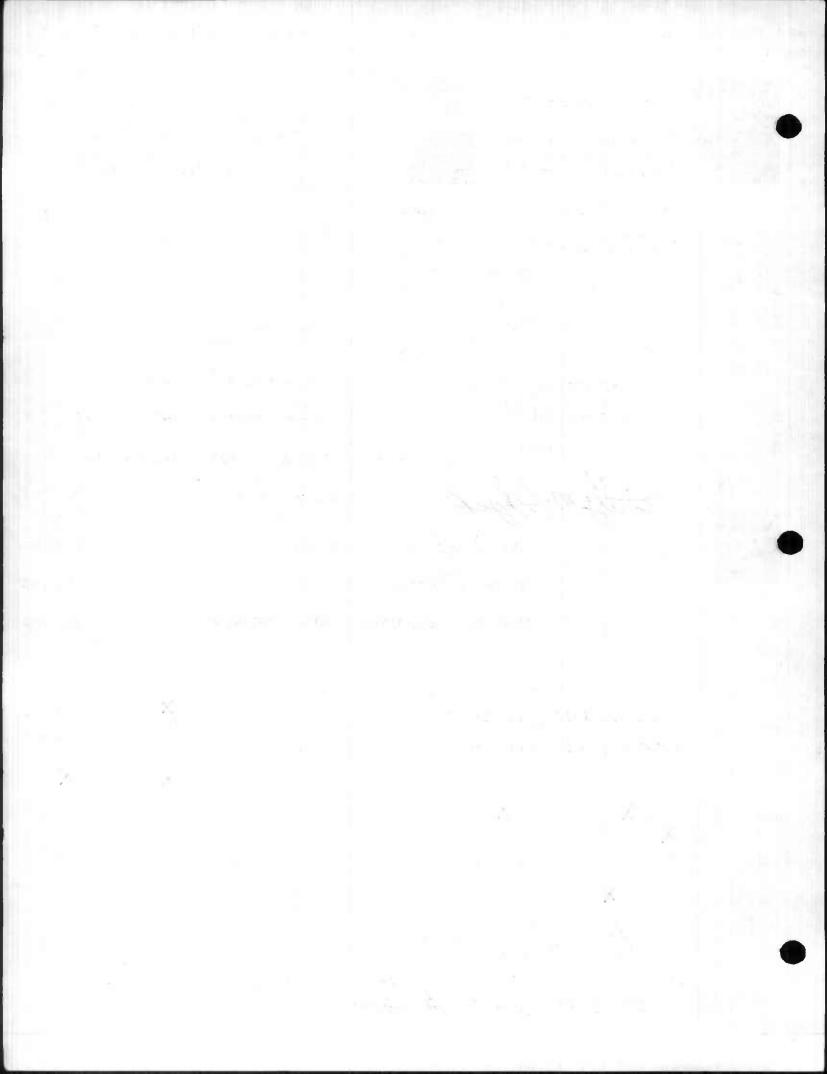
🌠 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and plece, and due to the ceuse(s) end menner es steted.

29a. Certifier

Medical

State Registrar





#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First Middle Lest) 2. Dete of Deeth Month Helen Teipe August 1999 8:15am 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Catonsville Commons Baltimore Catonsville If Undar 24 Hrs. Hours Min. 5. Social Security Number If Under 1 Yaar 6. Date of Birth (Month, Day, Year) Aug. 4, 1920 7. Age (In yrs. last birthday) Birthpleca (Steta or Foreign Country) Deys 1 □ M 2 🔀 F 217-05-8903 78 Yrs Maryland Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 16 Fusting Avenue 21228 United States 12. Wes Decedant Evar in U,S. Armad Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - Amaricen Indian, Black, White, etc. 1 Never Married 2 Married I ☐ Yes 2 ☑ No If Yes, Give Yaar or Detas: Specify: White 1 ☐ Yes 2 No Specify: 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Order Clerk Retail 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Emil Droll Elizabeth Gross 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Carol Reilly, Daughter 19 Old New England Road Stoney Creek, CT 06405 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State Lorraine Park Cemetery 8/5/99 Woodlawn, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Funeral Service Licensee 1328 Sulphur Spring Road Arbutus, MD 21227 23e. Paint: Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart fellure. List only one cause on each line. Approximata Intervel Between Onset end Death Immediate Ceuse (Finel heard Failure Iweek disaasa or condition resulting in deeth)

**Physician** /Medical **Examiner** 

end

signed by

After

Depertment important: If any Injury or

**Physician** 

/Medical

**Examiner** 

10a. State

**Funeral** 

**Director** 

items 23s or 28s-f show iner must be notified at

Director

Completed by Funeral

Be

nit. Peges 1 end 2 should be filed within 72 hours efter death with the Maryland direction of Heelth and Mental Hyglene. ortant: if item 27 is marked other than "natural", or items 23s or 28s-f show injury or other traumatic event, in Medical Exerting must be notified at

Maryland 21215-0020

Baltimore,

Physician/Medical Examiner ò Completed Be Certification: To To the Hospital or Attendir within 24 hours efter death. To the Funeral Director: At completely filled in by the fu

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Sequentielly list conditions, if any, leeding to immediate ceuse. Enter Underlying	b. Due to (	secural			
Cause (Diseese or Injury that initiated events resulting In death) Lest	Due to (	or es e consequance of):			
Pert II. Other significant conditions of					ontribute to the cause of death?
Chronic chetr	where full	nonnes D.	eslare	1 ☐ Yes 2 ☐ No	3 Probably 4 Unknow
Bépolar De	lare	0		24e. Wes en eutopsy performed?	24b. Were eutopsy findings eveileble prior to completion of cause of deeth?
				1 □ Yas 2 to No	1 ☐ Yes 2 ☐ No
25. Was cese referred to medical exeminer?			26. Plece of D	eath (Check only one)	
1 Yes 2 No	Hospital: 1 ☐ Inpetient 2 ☐	☐ ER/Outpatient 3☐ DOA	Other: 4 Nursing	Home 5 ☐ Residence 6 ☐Ot	her (Specify)
27. Menner of Deeth  1 SNaturel 5 Pending 2 Accident investigation	28e. Date of Injury (Month, Dey Year)	28b. Time of Injury M	i. Injury et Work? 1 ☐ Yas 2 ☐ No	28d. Describe how injury occu	rred
3 ☐ Sulcide 6 ☐ Could not be determined	28e. Plece of Injury - At h building, etc. (Speci	nome, ferm, street, factory, of	office	28f. Location (Street end Num City or Town, Stete)	ber or Rurel Routa Number,
29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my known that: On the basis of examine end menner steted.	owledge, deeth occurred et etion end/or Investigation, In	the time, dete end pled my opinion, deeth occ	ce, end due to the ceuse(s) end m curred et the time, dete end plece,	enner as steled. , end due to the cause(s)
29b. Signeture end title of certifier  Calha  Colona	ya WD	29c. (	a 7541	29d. Dete signed Augus	ed (Month, Dey, Year) £ 2 1999

State Registrar

Medical

31. Date filed (Month, Day, Yeer)

CUBETHA RAJA

32. Registrar's Signature

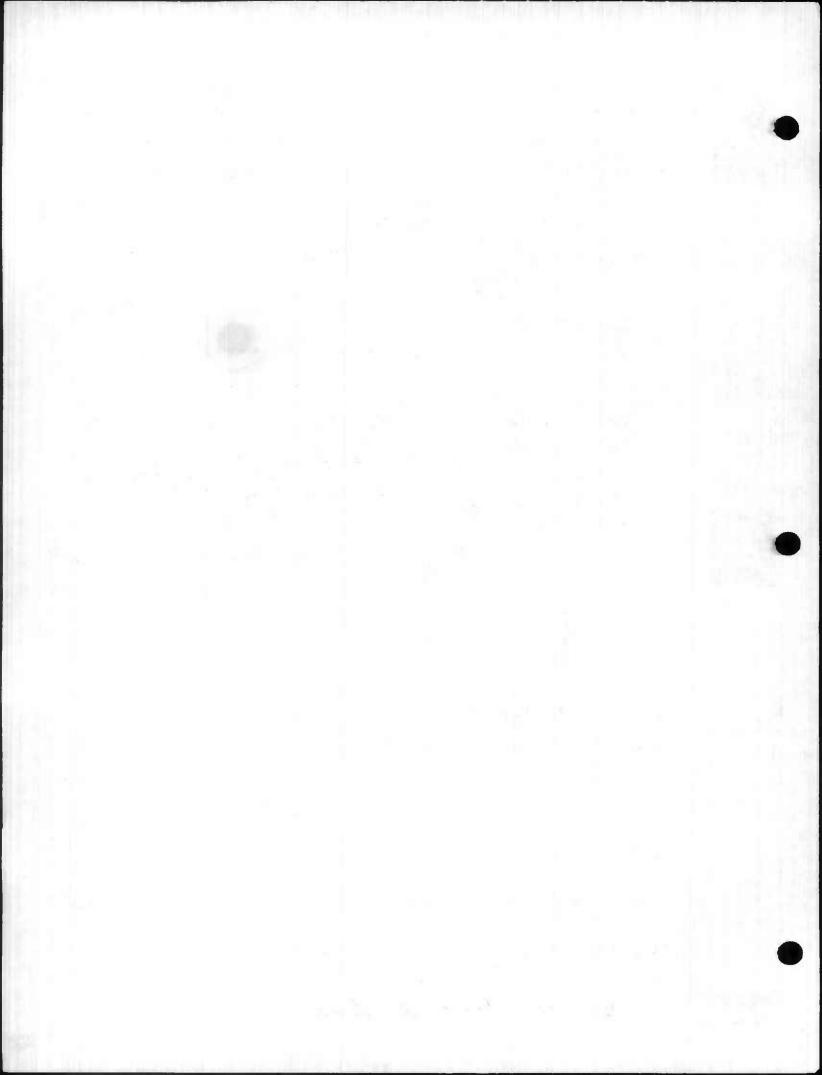
HOLLING

4367

PERAY AD, BALTIMULE, MD-21227

**DHMH 16 Rav 6/95** 

Skayor WD 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended Item#2 perPhyG774 8/2/99 EW 1. Decedent's Name (First, Middle, Last) 7-20-99 Day Yee 2. Date of Death Month 4a. Facility Name (It not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death 5. Social Security Number MD (inton If Under 24 Hrs. 6. Sex. 1 M 2 □ F If Under 1 Year 8. Date of Birth (Month, Pey, Yea 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) Days 219-167181 Yrs. 03/06 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 4 20 7 35 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 106 ineviewkane 14. Raca - American Indian, Black, White, etc. 11. Marital Status . Wes Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Farming 10th grade NA ather's Name (First, Middle, Lest) 18 Middle, Meiden Sumeme) Man Saules George Thomas, South Up: per Marlsoro Date 20t Location - City or Town, State (daughter Burial 2 Cremation 3 Removal from State ntion 5 Other (Specify) of Funeral Service Licensee 22, Name and Address of Fecility Mat you Fith West Ares Do not enter the mode of dying, such as cardiac or respiratory arrest, nter the disease, or complications that caused the death. or heart failure. List only one cause on each line. fer Hom immediate Cause (Final disease or condition resulting in death)

**Physician** /Medical Examiner

Department of Important: If any injury or

**Physician** 

/Medical

**Examiner** 

10a State

**Funeral** 

Director

"naturel", or items 23a or 28a-f show

Pages 1 and 2 should be filed within 72 hours eftar onent of Health and Mental Hygiane.
Int: If Item 27 Is marked other than "naturel", or item Iry or other traumatic event, in Montal Engine.

Baltimore, Maryland 21215-0020

Completed by Funeral Director

Be

the burial-transit or Attending Physician: To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral is

Division of Vital Records, P.O. Box 68760.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in deeth) Last  Pert II. Other significant conditions	· PArte	e consequence of):	i. Peil	Vas Du Nic	3 3 7
	contributing to death but not resulting	in the underlying caus	e given in Pert I.	23b. Did tobacco use co	ntribute to the cause of death?  3 Probably 4 Unknown
				24a. Was an autopsy performed?	24b. Were eutopsy findings available prior to completion of cause of death?  1 □ Yes 2 ☑ No
25. Was case referred to medical			26. Place of Dee	th (Check only one)	
examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/C	Outpatient 3 DOA	Other	ome 5 Residence 6 Oth	er (Specify)
27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigati	(Month, Dey Year)	injury	Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurr	
3 Suicide 6 Could not determine		farm, street, factory, of	lice	28f. Location (Street end Numb City or Town, Stete)	er or Rural Route Number,
29a. Certifier 1 Certifying P (Check only one) 2 Madical Exe	hysician: To the best of my knowledg miner: On the basis of examinetion a and manner stated.	ge, death occurred at the and/or investigation, in a	ne time, date and plece my opinion, death occu	, and due to the cause(s) and ma rred at the time, date and place, a	unner as stated. and due to the cause(s)
29b. Signature and title of partifier		29c. Lie	cense number	29d. Date signed	d (Month, Dey, Year)

oldarous

View Nursing

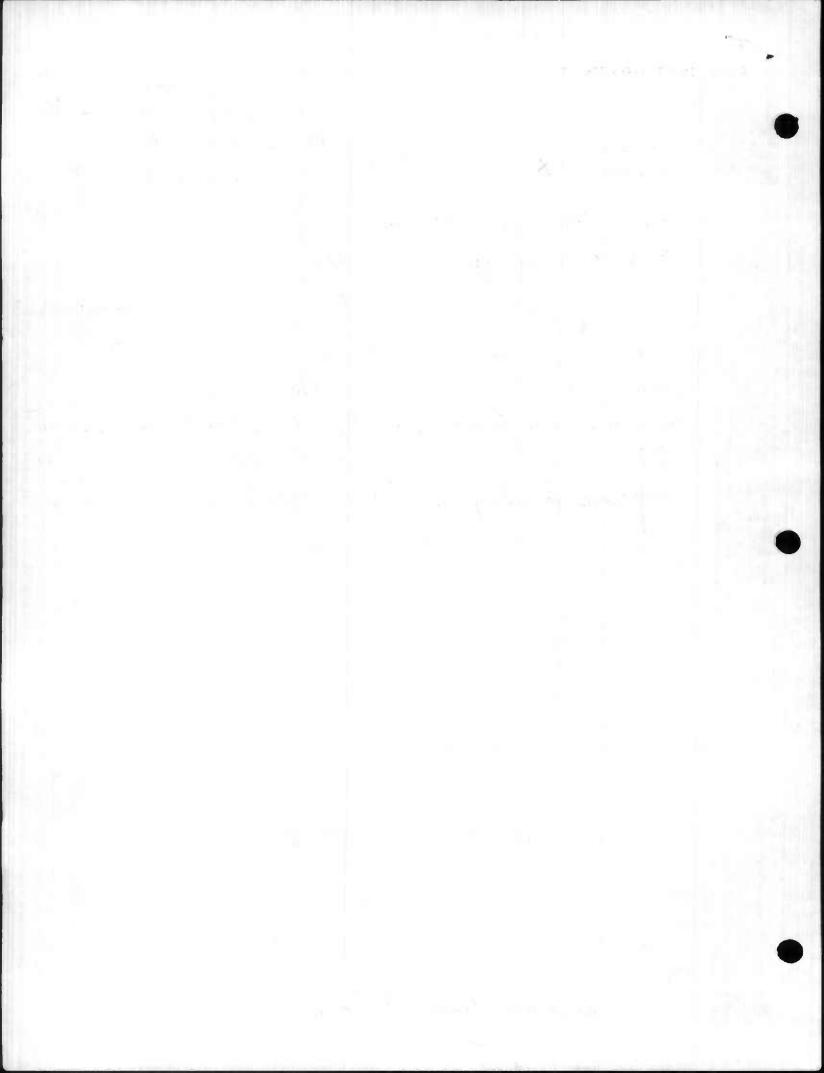
me and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra

31. Date filed (Month. Dev. Year)

DHMH 16 Rev 6/95

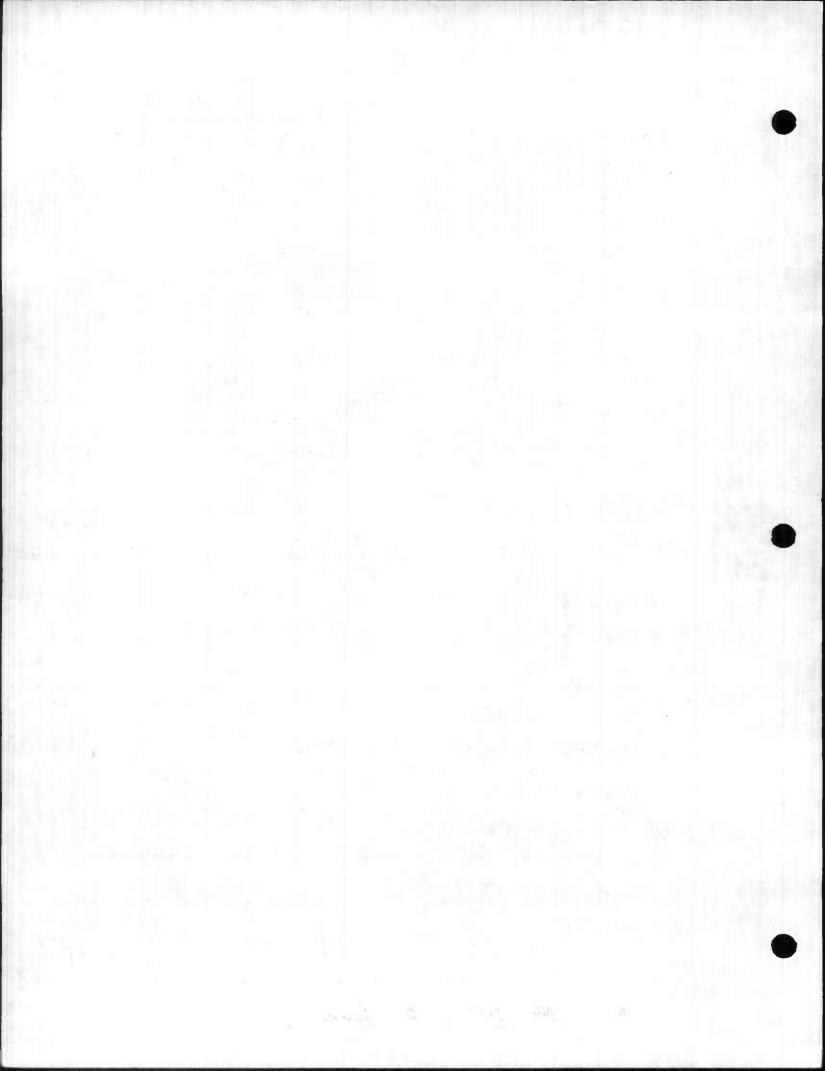
State Registrar



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

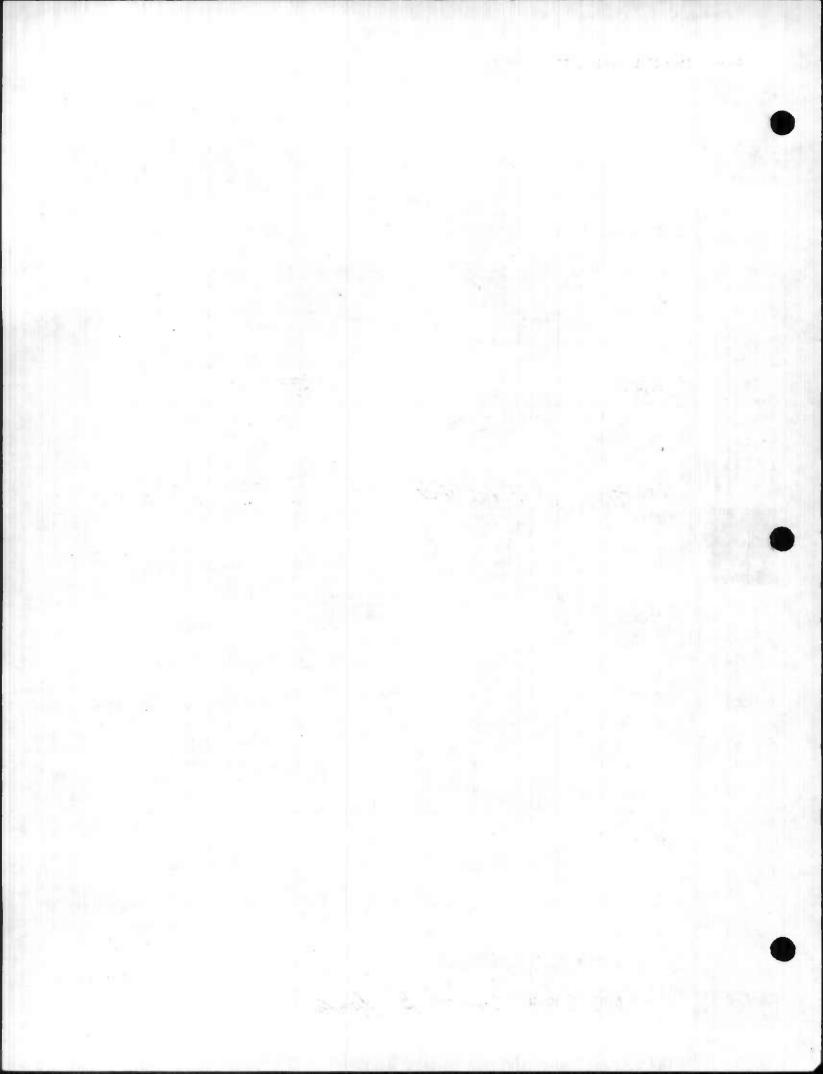
Division of Vital Records, P.O. Box 68760,

Decedent's Name	e /First Middle	( act)			Certifica	ate of	Death		2. Date of De	Reg. No.		3 Time	of Death
	SIMA			VA	YSTIKH				JULY 2	29, <sup>Dey</sup>	999 <sup>Ye</sup>	4:1	5 AM
4a Fecility Nama (/		give street and n NURSING					4b. City, Tow BALTI				County of D ALTIM		
5. Social Security N 214–41–	lumber	6. Sex 1 M 2 XF	7. Age (In ye	V	nday) If Unc Month	der 1 Year is Days	If Under 2 Hours		8. Date of Bi (Month, Di FEB 3	rth ay, Year)	-	Birthplace (Stat Country)	or Foreign
Usuel Residence of 10a. State	Decedent 10b. County				aud anation								
MD	BALTI	MORE		ALTIM	or Location							10d. Inside	s 2 No
10e. Street and Nur				10111		Zip Code				10a Citiza	en of What		Λ
4 AMLET		#2D			101.	Lip Oode	21215	5		rog. Onice	OIL OI VIIIM		AINE
11. Merital Status		12. Was De	cedent Ever in	U,S.	13. Was Dec	cedent of h	lispanic Orig	in? (Spe	cify Yes or No	0- 14		American Indian	.1110
1 ☐ Never Marri		Armed F ad 1 Yes If Yes, G Year or	3 2 No Give			2 No	an, Mexican, Specify:	Puerto F	ican, atc.)	s	Black, W Specify:	White, etc. WHI	ΓE
(Snec	15. Decedent	s Education t grade completed	-0		Decedent's Us			of workin	na	16b. Kind	d of Busine	ess/Industry	
Elementary/Seco			(1-4or 5+)		lile. DO NOT	use retire	d)						
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19e. Informant's Na	ame/Relationsh	in (Type Print)	•			ss /Street	and Number			her City or		ite, Zip Code)	17
	and the	DAUGHTER			SQUIR								
20a. Method of Disp				. Place of I	Disposition (A	lame of			Data			y or Town, State	
	☐ Cremation 5 ☐ Other (Sp	3 ☐Removal from	n State	The second second	crematory o			7/	/30/99	BAI	г.ттмо	RE, MD	
21. Significan of PV	A CONTRACTOR OF THE PARTY OF TH						es of Facility						
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#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

	Amended	State of Maryland / Department of Healt Item#17,18 perInf.G774 8/9/99 EW Certificate of Dea	ath	rgiene	PLIGH		
	Physician /Medical	Decedent's Name (First, Middle, Last)     Rose Ellen Williamson	2. Date of De Month July	Day Year 27,1999	3. Time of Death 10:15 AM		
	Examiner		ty, Town, or Location of Deat	th 4c. County of Death			
_			icott City	Howard			
	Funeral Director		ours Min. (Month, De		place (State or Foreign ntry) ryland		
	Pand III	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits		
	Man Man	Maryland Baltimore Baltimore			1 Yas 2 No		
	vith the Ma t or 28mf a be notified Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What Cou	ntry?		
	with w	1324 Lafayette Avenue 21207		USA			
020	72 hours after death with the Maryland natural, or items 23s or 28s-f show final Easther court be notified at etch by Funeral Director	11. Meritel Stetus  12. Wes Decedent Ever in U,S. Armed Forces? 1 Never Merried 2 Merried 3 Widowed 4 Divorced  12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes, specify Cuban, Merited 14. Yes, Size 15. Wes Decedent Ever in U,S. Armed Forces? 1 Yes, specify Cuban, Merited 16. Yes, Size 16. Yes 2 W No Specific Vision Specific Vision Specific Vision Specific Vision Specific Vision Specific Vision Specific Vision Specific Vision Specific Vision Specific Vision Specific Vision Specific Vision Visi					
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21215-0020	within then then	(Specify only highest grade completed)  Elementery/Secondery (0-12)  College (1-4or 5+)  Homemaker	most of working	Domestic			
Maryland	Halfiel H	17. Father's Name (First, Middle, Last)  Pranciseo Martin  18. M  Pranciseo Martin	Mother's Name (First, Middle Ora Luers	, Maiden Sumame)			
Man		19e. Informent's Neme/Reletionship (Type, Print)  19b. Mailing Address (Street and No. 1)					
	C = 0 -	Rosemary O'Hara Brooks/Daughter 1324 Lafayette					
Jor.	8 6 2 2	20e. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or To			
altimore,		4 Donation 5 Other (Specify)  Lorraine Park Cemete  21. Signeture of Funeral Service Licensee  22. Name and Address of F		Baltimore, M	aryland		
Ba	Departi Departi Importa eny inju	Kathleyn a Weber CFSP David J. Weber 5611 Edmondson	er Funeral Ho on Ave. Balti	more, Marylan	d 21229		
	Physician /Medical Examiner	23a. Part 1/Enter the disease or complications that caused the death. Do not enter the mode of dying, such shock, or heart feilure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	Λ		Iniérvel Between Onset end Death		
90,	be executed sician and burial-transit	Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury c					
x 68760,	phy s the	that initieted events		1			
Вох	eath certifi attending I for use as clar/Me						
, P.O.	ed by the detache	Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in F		tobacco use contribute t	obably 4 Unknown		
Records,	The law requires the sate has been signed, page 2 should be completed by			ormed?	/ere autopsy findings vailable prior to ompletion of cause death?		
H	The Laste has page		10	Yes 200 No 1	☐ Yes 2/15(No		
/ita	ysician: The secreticate director, page Co	axaminar/	Place of Death (Check only	one)			
of Vital	hya hya	1 Yes 2 No Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other:	Nursing Home 5 Resi		ify)		
	After fune	27. Manner of Death    Natural   5   Pending   28a. Dele of Injury   28b. Time of Injury   28c. Injury et Work?   1   Yes   28c. Specified   28c. Injury et Work?   1   Yes   28c. Injury et Work?   28c. Injury et Work?   1   Yes   28c. Injury et Work?   28c. Injury et Work?   28c. Injury et Work?   1   Yes   28c. Injury et Work?   28c. Injury		28d. Describe how injury occurred			
Divi		3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, alreet, fectory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	To the Hospital or At within 24 hours after To the Funeral Direc completely filled in by Medical Certifi	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, dated the companient of the basis of examination and/or investigation, in my opinion, and menner steted.	, death occurred at the time,	cause(s) and manner as a date and plece, and due to	stated. to the cause(s)		
	To the vithin To the comple	250. Signature and little of cultiflier 25c. License number 25c. L	2365	29d. Date signed (Month),	(Day, Year)		
	6:	30 Name and address of person who completed cause of death (Item 23a) (Type Print)	# 205/ E	Bold, MO	51558		
	State Registrar	31. Dete filed (Month Pay, Year) 1999 32. Registrar's Signature					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name /First, Middle Last) 2. Date of Death 3. Time of Death Month BEATRICE WATCHMAN 20:50 1999 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, giva street and number) 4c. County of Death Samaritan BALTIMORE BALTIMORE 161 igs all If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) Months Days 1 M 2 TEF 214-18-7125 Maryland Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD N/A Baltimore 1 Ves 2 No 10e. Streel and Number 10f. Zip Code 10g. Citizen of What Country? 4011 Fleetwood Avenue 21206 U.S.A. 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☒ No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decadent's Education 16b. Kind of Business/Industry rada complated) Elementery/Secondary (0-12) College (1-4or 5+) Cashier Drug Store 17. Father's Neme (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Surnama) Benjamin Miller Lottie Grace Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Steta, Zip Coda) Mark Rhoades/Grandson 738 Gullane Drive Charlesto SC. 29414 20b. Place of Disposition (Nama of cemetery, cramatory or other place)
Parkwood Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 8/2/99 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility John C. Miller Inc. 21. Signature of Funeral Service Licanses 6415 Belair Road Baltimore, Maryland 21206 the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) 14 days PEPTIC ULCER DISEASE Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Ihat initiated events resulting in death) Last Due to (or es a consequence of): Due to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the causa of death? 1 Yes 2 No 3 Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed? 1 Yes 1 TYes 2 No 25. Wes case referred to medical exeminer? 28. Place of Death (Chack only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 28e. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending Investigation 1 Netural 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide

Examiner The law requires that the death certificate be executed physician end s the burial-transit Box 68760, ettending p P.O. the signed by I Records, Deed pege 2 s certificate Division of Vital Hospital or Attanding Physician: diractor After death. after death Director: A

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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Funeral

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Completed

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Pages 1 and 2 should be filled within nent of Heelth end Mental Hygiene. int: If Itam 27 Ie merked other then '

permit. Pages 1 and 2 a Department of Heelth or Important: If Item 27 le eny injury or other trau

**Physician** 

/Medical

Examiner

Physician/Medical

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Certification: To

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29a. Certifier

(Check only one)

29b. Signature and litie of certified

Baltimore, Maryland 21215-0020

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the Funeral Direction of the funeral Direction of the funeral Direction of the funeral Direction of the funeral Direction of the funeral Direction of the funeral Direction of the funeral Direction of the fun within 24 hou To the Fune completely fil

> State Registrar

31. Date filed (Month, Day, Ye Alig 2 ABOUZAOUDE

29c. License number P12126

Certifying Physician: To the best of my knowledge, death occurred at the time, date and pleca, and due to the cause(s) end menner es stated.

Madical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end manner stated.

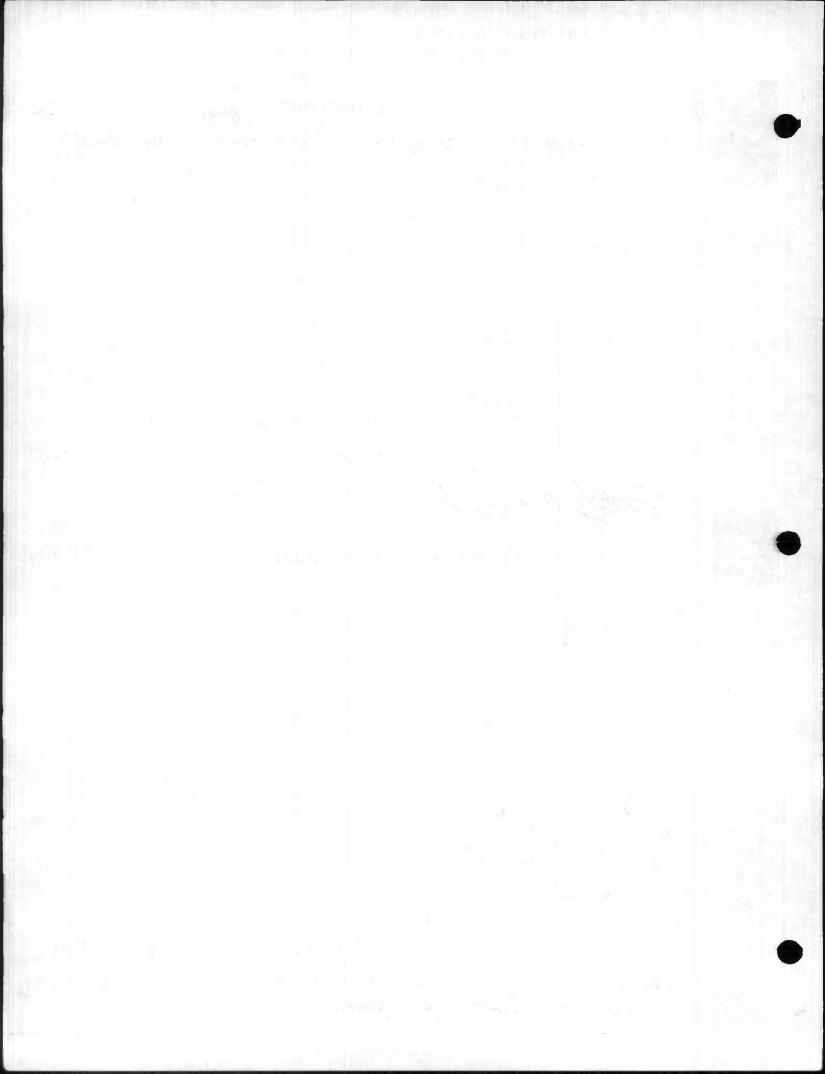
29d. Date signed (Month, Day, Year)

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

6920 DONACHIERD #705 BALTIMORE MD

32. Registrar's Signature

**DHMH 16 Ray 6/95** 



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** 105AN 29 HELEN MARTHA ZABLESKI )ulu /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number, 4c. County of Death Examiner os ed a - 15 If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Franklin Square Hospital Center Baltimore Cos If Under 1 Year 7. Age (In yrs. last birthdey) Birthplace (Steta or Foreign Country) 5. Sociel Security Number 6. Sex **Funeral** Deys 1 □ M 2/□ F Yrs 10, 1916 WASH. D.C. Director 216-07-4283 Usuel Residance of Dacedent with the Maryland 10e. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiens.
Itsm 27 is marked other than "nature!; or items 23a or 28a-f show other traumetic syent, the Modical Examine must be notified at BALTIMORE ector MD. 1 ☐ Yes 2 ☐ No ROSEDALE 10e. Straat and Number 10f. Zip Coda 10g. Citizen of Whet Country? 눕 1315 CHESACO AVE. APT. #213 21237 U.S.A. Funeral 12. Was Dacedant Evar in U,S. Armed Forces? Was Dacedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Ricen, etc.) 14. Race - American Indian, Black, Whita, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE g 3 XWidowed 4 ☐ Divorced Zableskis, Helen Completed 16e. Decedent's Usuel Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 8TH HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Meiden Sumeme) Be Pagas 1 and 2 should be nant of Haalth and Mental STEPHEN REDA FRANCES JANKIEWICZ P 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) permit. Pages 1 and 2: Department of Health at Important: If itsm 27 is any injury or other training. JAMES ZABLESKI/SON 8907 TALC DR. APT 1B, BALTIMORE, MD. 21237 20b. Plece of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Dete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Othar (Specify) SACRED HEART OF JESUS 8/2/99 BALTIMORE, MD 21. Signature of Funerel Service 22. Name end Address of Fecility MORAN ASHTON DABROWSKI FUNERAL HOME 3000 E. BALTIMORE ST. BALTIMORE, MD.
enter the mode of dying, such as cardiac or raspiretory errest, 21224

Approximate Intervel Between Onset end Deetl 23e. Pert1. Enter the diseatury or complications that ceused the death. Do not enter the mode of dying, such as cardiac or raspiretory errest, shock, or heert feilure. List only one ceuse on eech line. **Physician** /Medical Immedieta Causa (Final Unknown disaasa or condition resulting in daeth) Examiner Physician/Medical Examiner physician and s the burial-transit law requires that the death certificate be assecuted Sequentielly list conditions, if eny, laading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated evants rasulting in death) Lest Dua to (or as a consaquance of): P.O. Box 68760, Due to (or es e consequence of) attending p signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 1 Yas 2 No 3 Probably 4 Unknown Division of Vital Records. þ should t 24b. Were eutopsy findings evaileble prior to complation of causa of deeth? Completed 24a. Wes en eutopsy irector, page 2 s Tha 1 Yes 2 No 1 ☐ Yas 2 ☐ No Hospital or Attending Physician: funeral director. 25. Wes cese referred to medicel Be 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpetient 2 ER/Outpetient 3 DOA Certification: To this 28e. Dete of Injury (Month, Dey Year) 27. Mannar of Deeth 28b. Tima of 28d. Describe how Injury occurred 28c. Injury et Work? Aftar 5 Pending invastigation 1 Naturel 2 Accident daath. 1 ☐ Yas 2 ☐ No To the Hospital or Atterwithin 24 hours after der To the Funeral Directo completely filled in by the 3 ☐ Suicida 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicida Certifying Phyalcian: To the best of my knowladga, deeth occurred et the tima, date end piece, end due to tha causa(s) and mannar es stetad.

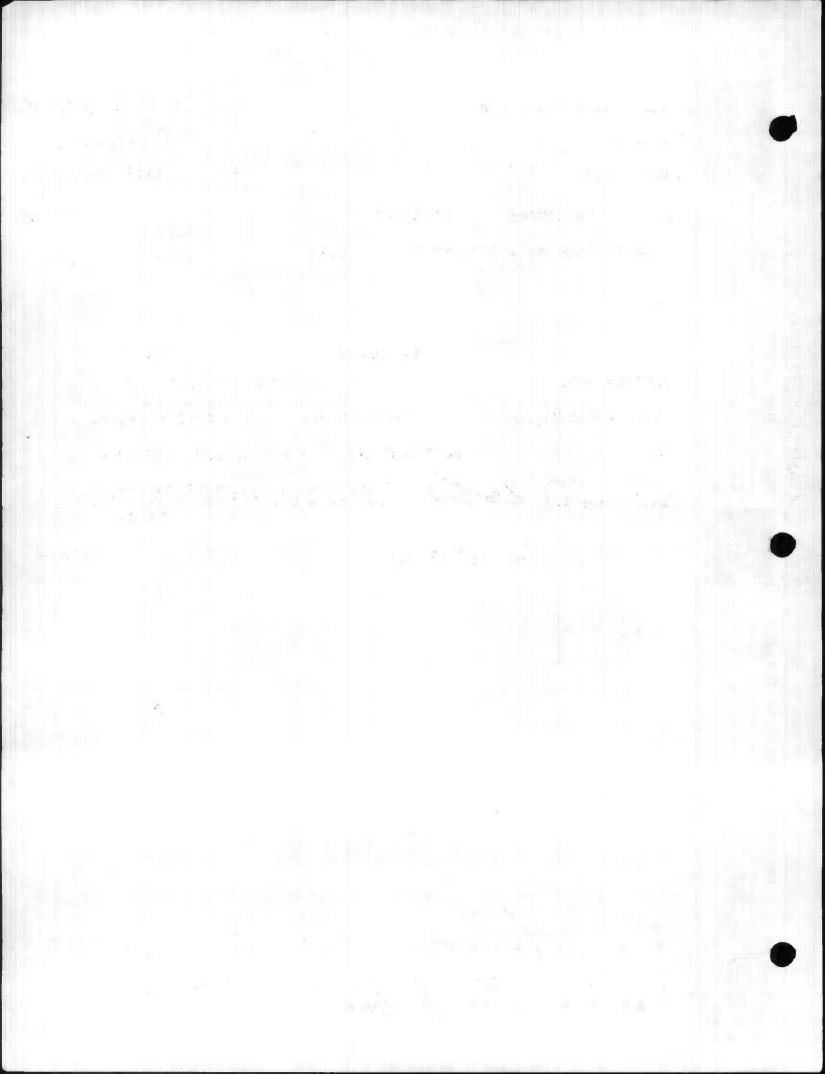
Madical Examiner: On the bests of examinetion end/or investigation, in my opinion, death occurred et the time, data and place, and dua to the causa(s) and menner steted. Medical 29a. Cartifian 29d. Dete signed (Month, Dey, Year) 29b. Signetura end titla of cedillor 29c. License number WARNOW

9000 Franklin Square Drive Battimore

State Registrar 30. Name end eddrass of person who completed ceuse of death (Item 23a) (Type, Print)

32. Registrar's Signeture

Jarn



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 0137am 1999 HAKIM ABDULLAH JULY /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deat Examiner BALTIMORECITY BALTIMONE HOSPITAL OF IAMIC 5. Social Security Number 214-58-7785
Usuai Residence of Decedent If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 100 M 2□ F Days Yrs. land Director with the Maryland 10b. County 10a. State 10d. Inside City Limits Item 27 is marked other than "natural", or Itema 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 XYes 2□No Director more and Number 10f. Zip Code 10g. Citizen of What Country? 1ge Stre Funeral Seath 12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Maritai Status permit. Peges 1 and 2 should be filed within 72 hours after to Department of Health and Mental thygiene. Important: If Item 27 is marked other than "natural", or Item any Injury or other traumatic event, the Medical Fran 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: à *American* 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuei Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coilega (1-4or 5+) (First, Middle, Last) Name (First, Middle, Maiden Sumame) 8 2 Informant's Name/Relationship (Type, Pres (Sister 19b. Mailing Address (Street and Number or Rural Route Number. City or Town, State 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition competery, crematory or other place) 1 Burial 2 Cremation 3 R 3 Removal from State 0 -10n Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph Her ie, or complication's that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, List only one ceuse on each line. Md. 212 **Physician** immediate Cause (Final disease or condition resulting in death) /Medical HYPERKALEMIA 5hrs Examiner Due to (or as a consequence of) physician and s the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of): P.O. Box 68760 Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Onknown END STAGE RENAL DISEASE. Division of Vital Records. à 24b. Were autopsy findings available prior to Completed 24a. Wes an autopsy performed? completion of cause of death? 1□ Yes 20 No 1 Yes 2 No or Attending Physician: after death. Director: After this certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 SER/Outpatient 3 DOA 28e. Date of Injury (Month, Day Year) funeral 27. Manger of Death Certification: 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Naturai 5 Pending 2 No 1 Yes 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours all To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. pletely (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and piaca, and due to the cause(s) and manner stated.

Registrar

IARIQ 31. Date filed (Month, Day, Year)

AUG 03 1999

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

29b. Signature and title of certifier

SINAI 32. Registrar's Signature

29c. License number

DOD21730

29d. Date signed (Month, Day, Year)

YUUL

Comment of the country

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day JULY 15, 1999 3 A.M. 4a Facility Neme (If not Institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth GREENSPRING NSG. REHAB CENTER BALTIMORE If Under 1 Year 8. Date of Birth (Month, Dey, Yeer) JUNE 13,1913 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) Hours Months 1 M 2 XF Days SOUTH CAROLINA 247-26-6210 Usual Residence of Decedent 10a. Stata 10c. City. Town or Location 10d. Inside City Limits 10b. County 1 Yas 2 □ No MARYLAND BALTIMORE 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 21202 USA 1105 E. CHASE ST. 12. Was Decedant Evar In U,S. Armad Forcas? 1 ☐ Yas 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Ricen, atc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Marriad 2 Married 1 ☐ Yes 2 No Specify: Specify: AFRO. AMERICAN 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grada completed) Elemantary/Secondary (0-12) Collega (1-4or 5+) HOMEAKER HOME 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Meiden Sumame) **CRESSE** ADAMS ISIAH **ADAMS** 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straet end Number or Rural Route Number, City or Town, State, Zip Code) **ADAMS** 900 STODDARD ST. BALTIMORE, MARYLAND 21201 20b. Place of Disposition (Neme of cemetery, crematory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, State 1 Buriai 2 Cramation 3 Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) MT. ZION CEMTERY 7/23/99 LANSDROWN, MD. 22. Nama and Address of Facility 21. Signature of Funeral Service Licenses ESTEP BROTHERS FUNERALSER, P. A. 1300 EUTAW PLACE, BALTIMORE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast shock, or heart Jailure. List only one cause on each line. Approximate Intervel Between Onsat and Death e. CAOCEL BLADDER\_METASTATIC

Due to (or as e consequence of):

CAOCEN BLADDER

Dua to (or es e consequence of): Immediata Causa (Final disaase or condition resulting in daath) Dua to (or es a consequence of) 23b. Did tobacco use contribute to the cause of death? [ Rack 1 Yes 2 No 3 Probably 4 Unknown Te che 24b. Were autopsy findings evailable prior to 24e. Was en autopsy completion of cause of death?

**Physician** /Medical Examiner

signed by t

Completed

Be

Certification:

Medical

other 1

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**Physician** 

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death hart of Health and Mental Hygiene.

If item 27 is marked other than "natural", or items 23

Baltimore, Maryland 21215-0020

.O. Box 68760

Division of Vital Records, P.

Hospital or Attending Physician:
 24 hours after death.
 Funerel Director: After this certific

To the Hospital or Atte-within 24 hours after de-To the Funeral Director completely filled in by the

Directo

Funeral

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with the Maryland

Examiner the bunal-tran Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Ceusa (Diseasa or Injury that initiated evants rasulting in death) Lest Physician/Medical

Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause givan in Part I.

1 Yas 2 NO 1 ☐ Yes 2 ☐ No

25. Was casa rafarrad to medical examiner? 1 Yes 2 No 27. Mannar of Death 1 Natural

1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury et Work? 28b. Time of

Other: 4 Norsing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred

26. Place of Death (Check only ona)

5 Panding Investigation 2 Accidant 3 Sulcide 6 Could not be datarminad 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29e. Certifiar 29b. Signatura and titla of certifiar

1 Certifying Physician: To the best of my knowledge, daeth occurred at the time, dete and piece, end dua to the ceuse(s) and manner as stated.
2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, daath occurred at the time, date and place, and dua to the cause(s) and manner stated. 29c. License number

1 ☐ Yas 2 ☐ No

Ten 177 ENDING BHESTOND 13248

29d. Data signed (Month, Day, Year)

JULY 22, 1999

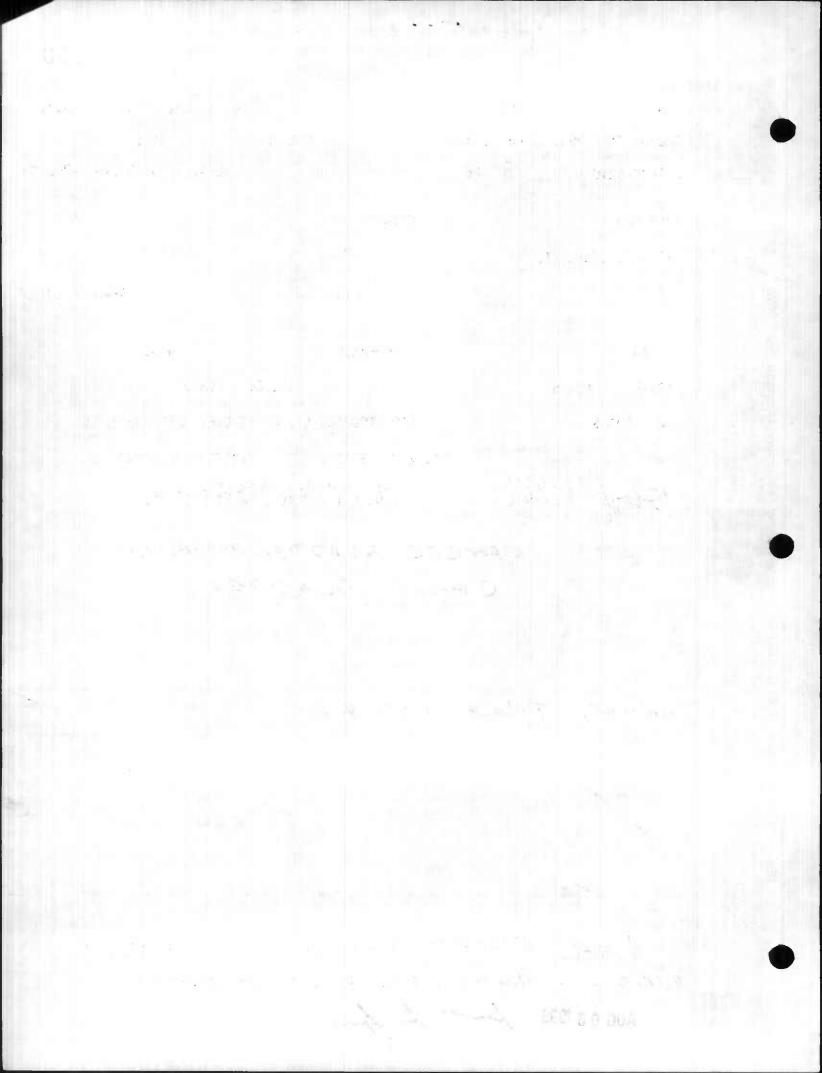
30. Name end address of person who completed cause of death (item 23a) (Type, Print)

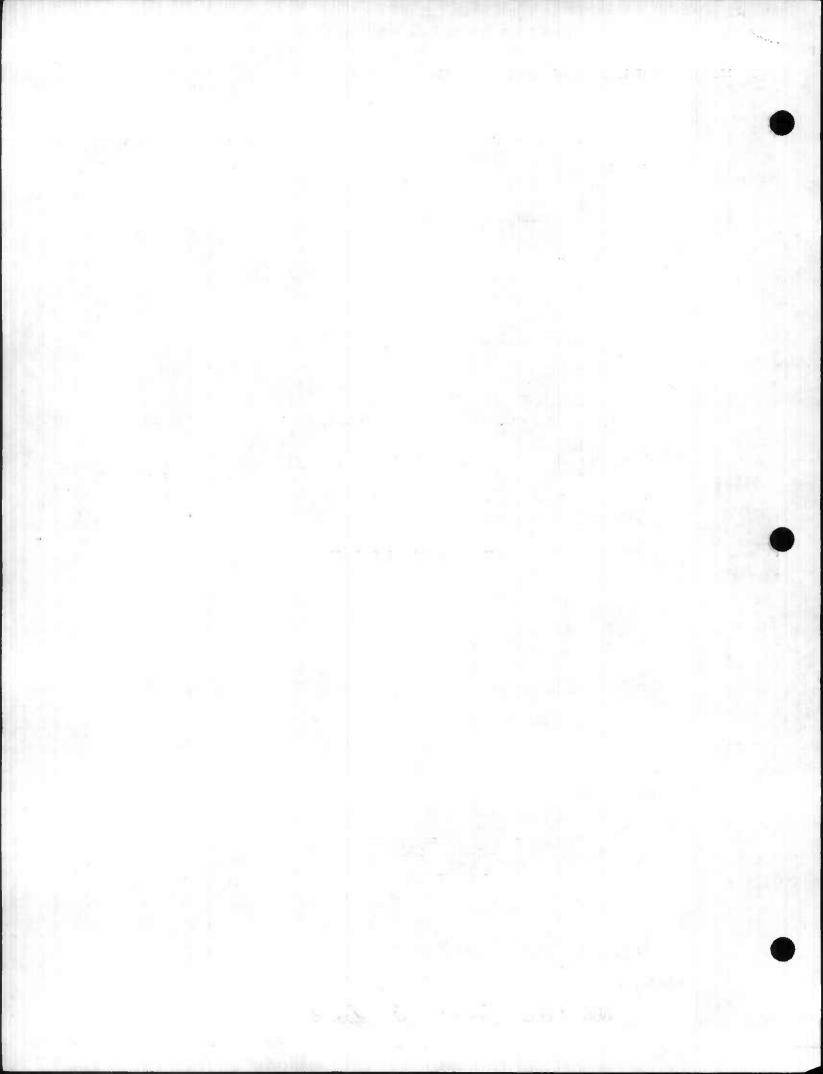
5 - 5 23/44 1510 W. MOSHER STREET, BALTIMORE, MARYLAND 21217 31. Data filed (Month, Day, Year)

State Registrar

AUG 0 3 1999

32. Registrar's Signature





#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Florence B. Allard July 31,1999 3:40am /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore 7. Age (In yrs. lest birthday) If Under 1 Year Months Days 5. Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 29 1920 Birthplace (State or Foreign Country) Maryland 6. Sex **Funeral** Days Hours Min 1 □ M 2X F 79 220-05-3289 Director Usual Residence of Decedent a or 28a-f show 10e. Stete 10h County 10c. City, Town or Location 10d. tnside City Limits 1 ☐ Yes 2 ☑ No Director MD Baltimore Glen Arm 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21057 234 11630 Glen Arm Rd. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Meritel Stetus Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Merried 'natural', or 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) 12 Balt. Co. Board of Ed. Secretary Department of Health and Mental Hy, Important: If Item 27 is marked other any injury or other transcent. 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Beever Elmer Edna Franks 10 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Col. C.Kenneth Allard/ Son 1809 Stirrup Ln. Alexandria, Va. 22308 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1X Burial 2 ☐ Cremetion 3 ☐ Removel from State 8-3-99 Parkville, MD. Moreland Cemetery 4 Donetion 5 DOther (Specify) 21. Signeture of Funerel Service Licensee 22. Name and Address of Facility on Funeral Home, 1050 York Rd. Towson, MD. 23a. Pert1. Enter the disease, or combligations that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** · PULMONARY EMBOLISM Immediate Cause (Final disease or condition resulting in death) /Medical hours Examiner angestive Examiner burial-transit that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Carcho Vacantor disease Box 68760. Physician/Medical the Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco usa contributa to the cause of death? Division of Vital Records, P.O. Hypothy roidism 1 Yas 2 No 3 Probably 4 Unknown by Astheria 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed completion of cause of death? No 1 Yes 2 No or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 DKNo edical Certification: To this 28a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Neturel a Euneral Director: At bletch filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours at To the Funeral Di completely filled is

(Check only one)

29b. Signeture end till certifier Rhopsupo

AUG 0 3 1999

29c. License number D51228

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Madical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner steted.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RIMAN A GOPACAN MD LEAST ROLLING CRUSTROADS # 59 BACTIMORE 32. Registrer's Signature 31. Dete filed (Month, Day, Year)

MD

State Registrar

allard, Florence

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMENDED ITEM #31 per dvr G774 8/3/99 AH Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year 11:00AM Margaret 31, 1999 July 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harborside Health Care Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) June 26, 1910 9. Birthplaca (State or Foreign Country) Maryland 7. Aga (In yrs. last birthday) Months Days 10M 20F 215-14-9300 89 Yrs. Usual Rasidence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1X Yes 2 No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21239 1657 East Belvedere Avenue United States 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No 14. Race - Amarican Indian, Black, Whita, atc. Was Decedent of Hispanic Origin? (Specify Yas or Notif Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11. Merital Stetus 1 Nevar Married 2 Married Specify: White 1 Yes 2 No Specify: If Yas, Giva Year or Dates: 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Housewife Own Home 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Henry Leonard Annie Rammes 19a. Informant's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leonard Bunce/Son 4122 Townsend Avenue, Baltimore, Maryland 21225 20b. Place of Disposition (Name of 20c. Location - City or Town, Stata Data More land Mellior i al Park 08/03/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Address of Facility Lec nard J. Ruck, Inc. 21. Signature of Funeral Service Licensee Christina L. David 5305 Harford Road, Baltimore, Maryland 21214 NUSTIDA 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona cause on each line. Immediata Causa (Final diseasa or condition resulting in death) NEUMONIA ( DAY Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of): Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown ALNUTALTION) 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yas € CoNo 1 ☐ Yes 2 ☐ No 25. Was casa raferred to medical 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpetient Other: 4 Divising Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending invastigation Naturat 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be detarmined 281. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 - Homicide

P.O. Box 68760, Records, **Physician** 

/Medical

Examiner

MD

Director

Funeral

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Completed

**Funeral** 

Director

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death

filed within 72 hours after

21215-0020

Maryland

altimore.

Peges 1 and 2 should be filed within 72 hours aft nant of Heath and Mental Hyglene.
Int: If flem 27 le marked other than "natural", or uny or other traumatic event, the Medical Event.

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**Physician** /Medical

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Certification: To

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The law requires that the death certificate be executed Division of Vital Attending Physicien: al or Attendin after death. Director: Aft To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the

> State Registrar

**DHMH 16 Rev 6/95** 

31. Data filed (Month, Day, Year)

29a, Certifier (Check only one)

29b. Signatura and litla of certifier

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) au

Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to the cause(s) and mannar as stated.

| Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the tima, data and place, and dua to the cause(s) and mannar stated.

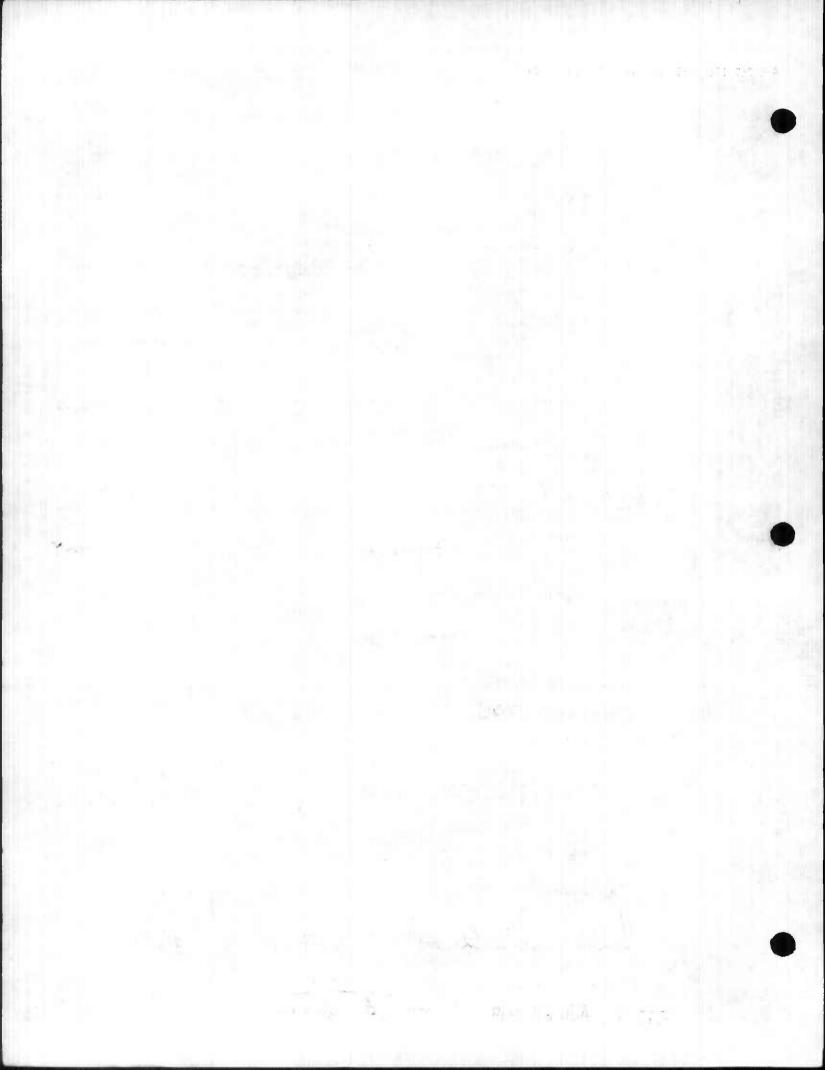
29c. License number

29d. Data signed (Month, Day, Year)

P.OB Suite 5001 Lah Raven Blud Banto Md. 21239

32. Registrar's Signature

**ORIGINAL** 



#### Please Type or Print In Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent'a Name (First, Middla, Last) 2. Dete of Death Dey Month brown 4a Facility Name (If not institution, give street and number) 03:42 99 9 4b. City, Town, or Location of Death 4c. County of Death Baltimore Coltimore 0+ Mary land univers ty If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthday) 5. Social Security Number 6. Sex Birthplace (State or Fareign Country) Days 20 1 M 2 F Months 6 Maryland Usuel Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location NOXYes 2 No NA Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6219 Shipview Way 21224 U.S.A 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2X.5% Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian. 11. Marital Status Black, White, atc. Wevar Marriad 2 Married 1 Yes 2 No Specify: Black Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast greda complated) Elementary/Secondary (0-12) College (1-4or 5+) Infant Infant 17 Father's Name (First Middle Last) 18. Mothar's Name (First, Middle, Meiden Sumeme) James L. Brown Sr. Sylvia A. Brown 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a, Informant's Name/Raiationship (Type, Print) 6219 Shipview Way, Baltimore, MD 21224 Sylvia A. Brown (mother) 20b. Plece of Disposition (Neme of 20a. Method of Disposition Data 20c. Location - City or Town, State cametery, crematory or other piece) Loudon Park Cemetery 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/31/99 Baltimore, MD 21. Signatura of Funaral Service Licensee 22. Nama and Addrass of FacilityLoudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Md 21229 23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or haart failure. List only one cause on each line. Approximata Intarvat Batween Onsat and Death fmmediata Causa (Finat diseasa or condition rasulting in death) 515 Dua to (or as a consequence of) side (MOLUSI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or Injury that Intieled avants rasulting in death) Last Due to (or as a consequence of): Due to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 TYes 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 2 2 No 1 Tyes 1 ☐ Yas 2 ☐ No

26. Place of Death (Chack only one)

Other: 4 Nursing Home 5 Rasidence 6 Other (Specify)

28d. Dascribe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Data signed (Month, Dey, Year)

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

10a. Stata

**Funeral** 

Director

**WOHe** 

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Directo MD

Funeral

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death

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Department of Health and Mental Hygi Important: If Item 27 is marked other any injury or other traumatic event, It

Baltimore, Maryland 21215-0020

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page 2 certificate funeral director,

Examiner Physician/Medical P Completed Be 10 Certification:

requires that the death certificate be exec Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific completely filled in by n 24 hours a

1 Yes 2 No 27. Manner of Death 1 Naturel 2 Accidant 3 Sulcide 4 T Homicide

Medical

State

Registrar

29a. Cartifier

(Check only one)

(0 31. Date filet (Month, Dey, Yaer)

29b. Signature and title of certifiar

25. Was case referred to medical axaminar?

5 Panding investigation

6 Could not be

Kerman 32. Registrer's Signature

Inpatient

28a. Date of Injury (Month, Day Yaar)

and mannar stated.

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, afc. (Specify)

28c. Injury at Work?

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to tha cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha causa(s)

29c. Licanse number

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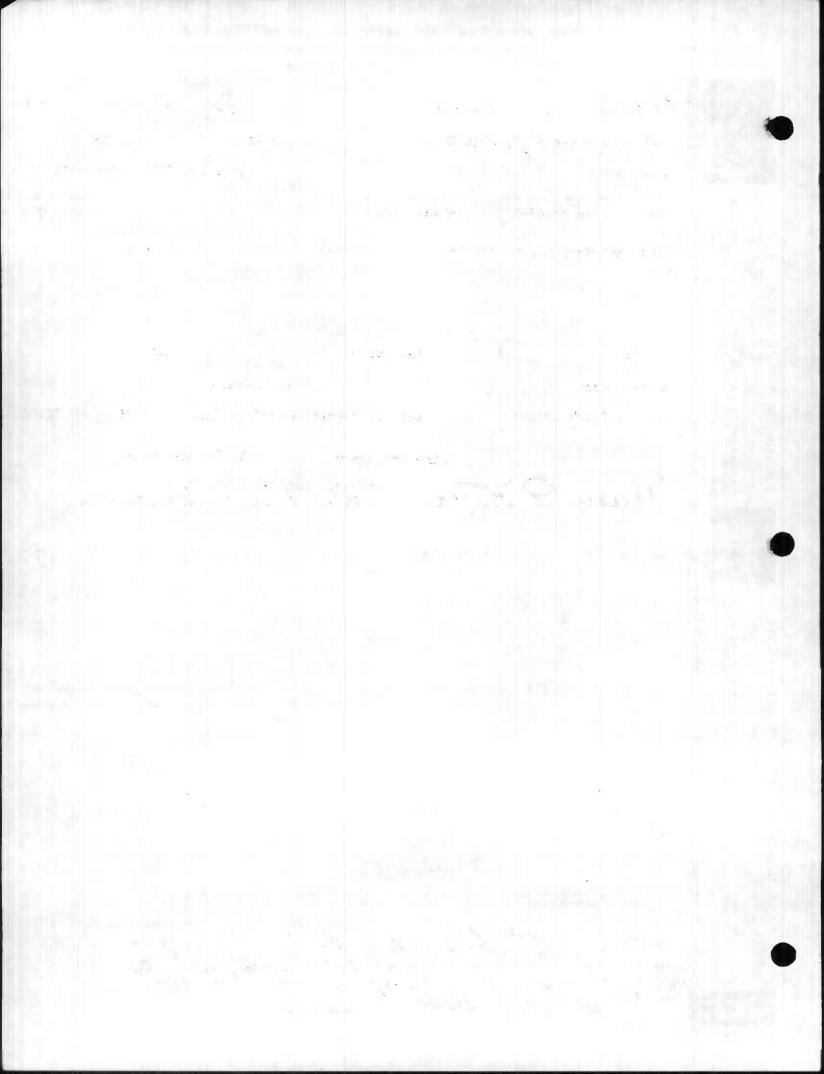
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State of Maryland / Department of Health and Mental Hygiene 9 9 24 173

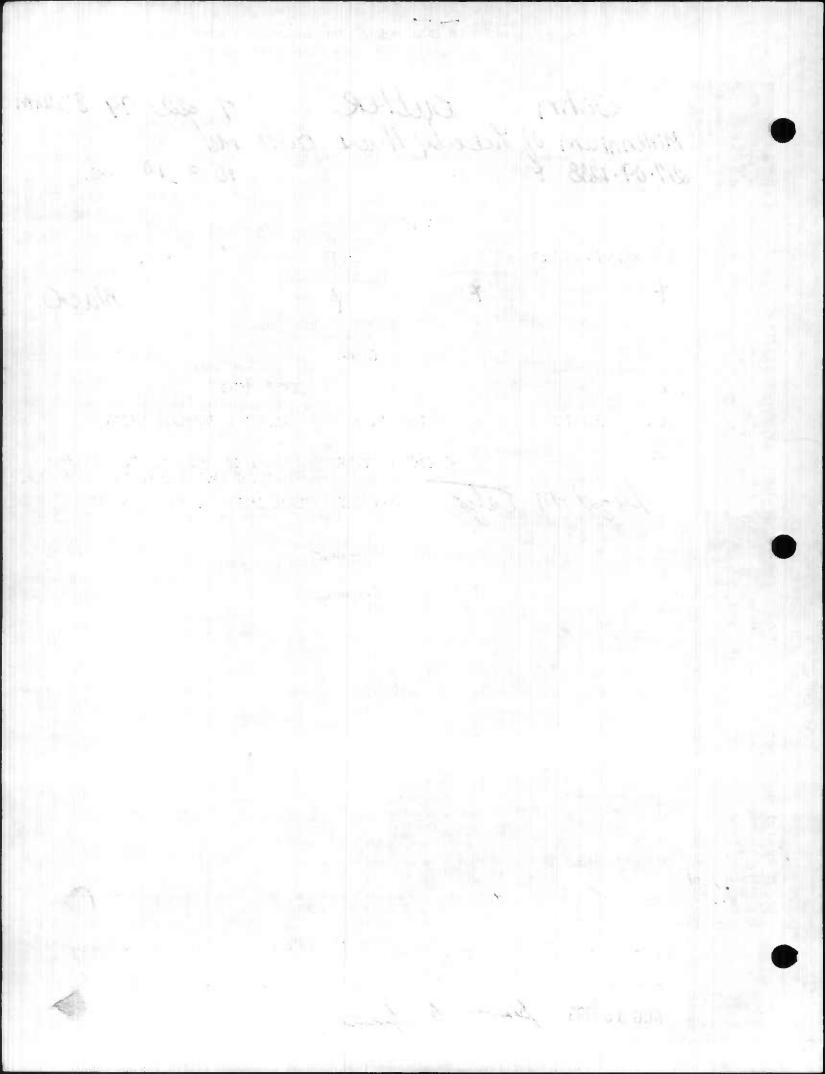
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MUSTE



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 2 Date of Death 3. Time of Death Month Yaar **Physician** SIRBTA BURRELL 3 15 AM 999 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BON SECOURS HOSPITAL BALTIMORI 5. Social Security Number 200 6. Sax 7. Age (In yrs. last birthday) Birthplaca (Stata or Foraign Country) Data of Birth (Month, Day, Year) **Funeral** Days 1□ M 2♥ F 214-64-6316 Yrs. Director 8-7-62 36 md. Usual Residence of Decedent should be filed within 72 hours effer death with the Maryland and Mantel Hygiene.

marked other than "neturel", or fferre 23e or 28e-f ahow imatic avent, the Medical Examiner must be nutrified as 10a State 10b County 10c. City, Town or Location 10d. inside City Limits 1 Yas 2 No MD. Director BALTIMORE 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 500 GLEN ALLEN DRIVE 13. Was Decedent of Hispanic Origin? (Specify Yes or Noff Yes, specify Cuban, Maxicen, Puerto Rican, atc.) Funeral 4. Hace American Indian. 12. Was Decedent Ever in U,S. Armed Forcas? Black, Whita, atc. 1 Never Married 2 ☐ Married 1 Yas 2 No If Yes, Give Year or Datas: 1 Yas 2 No Specify: Specify: BLACK by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highast grada completed) 16a. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Deemit. Pages 1 and 2 should be filed.
Department of Health and Mentel truch Important: if fiem 27 is marked any injury or other. 17. Fathar's Nema (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) WALTER BURELL DEBRA BURELL 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 500 GLEN ALLEN DR. BALTIMORE MARYLAND 21229
ace of Disposition (Nama of Data 20c. Location - City or Town, State DEBRA BURELL 20a. Mathod of Disposition 20b. Place of Disposition (Nama of camatary, cramatory or other place) 1 Burial 2 Cremation 3 Ramoval from Stata mt zion cenetery 7-24-99 BALTIMORE MARYLAND 4 Donation 5 Othar (Specify) 22. Nama and Addrass of Facility ESTEP BROTHERS FUNERAL HOME P.A. 21. Signature of Funaral Sarvice Licenses BALTIMORE MARYLAND Part1. Entar/the disease, or complications that ceusad the death. Do not enter the shock, or heaft failure. List only one cause on each line. mode of dying, such as cardiac or respiratory arrast, Approximata Interval Between Onsat and Death **Physician** Immediate Causa (Final disease or condition resulting In deeth) /Medical **Examiner** Examiner bha physician and the burial-transit lew requires that the death certificate be axecuted Sequantially list conditions, if any, leeding to immadiate ceuse. Enter Undarlying Causa (Disaasa or injury thet initieled events rasulting in daath) Last Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medicai Dua to (or as a consequence of): attending pl signed by the a Pert fl. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings available prior to completion of ceusa of death? 24a. Was an autopsy performed? Completed certificate has b lirector, page 2 s 2 No 1 Yas 1 ☐ Yas 2 ☐ No Hospital or Attanding Physician: 24 hours after death. Funeral Director: After this certifica staty filled in by the funeral director, 25. Was cesa raferred to medicel examinar? Be 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No Certification: To patient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28rl. Dascribe how injury occurred 28c. Injury at Work? 5 Panding invastigation Waturel 1 TYes 2 No 2 Accidant 6 Could not be determined 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida To the Hospital or within 24 hours aft To the Funerel Di completaly filled in 1 Certifying Physician: To tha best of my knowledge, death occurred et the tima, data and place, and dua to tha ceusa(s) and mannar es stated. Medical 29a. Cartifian 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. 29b. Signature and titla of certifiar 29c. Licansa number 29d. Dafe signed (Month, Day, Year) 30. Nama and address of person who completed ceusa of deeth (Itam 23a) (Type, Print) MD 4419 FALLS ROBBLEOM D2121 UBEROL 31. Data filed (Month, Day, Year)

SHY

State Registrar

**DHMH 16 Rev 6/95** 

AUG 0 3 1999

32. Registrar's Signeture

egistrar's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** elle 24,1 James Theodore Beverly, Sr. /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Death **Examiner** Northwest Hospital Randallstown Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplaca (State or Foreign Country) **Funeral** M 2□ F Months Days 219-05-0012 Yrs. **Director** May 19, 1914 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or items 23s or 28s-f ahow any injury or other transmitted own, im Medical Espations may be notified at any injury or other traumatic event, im Medical Espations may be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Md. n/a Baltimore Yes 2□ No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21216 2302 W. Mosher Street USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 240 No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11 Meritel Stetus Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: Black þ 3€Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Induatry mentery/Secondery (0-12) College (1-4or 5+) 12th Grade Machinist Western Electric 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Emma Beverly George Sterling 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) son James T. Beverly, Jr. 2302 W. Mosher Street Baltimore, Md. 21216 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) July 31 Baltimore, Md. New Cathedral Cemetery 5 Other (Specify) of Funeral Service Licens 22. Name and Address of Facility Nutter Funeral Homes, Inc. 21. Signature 2501 Gwynns Falls PKWY Baltimore, Md. 21216 ٤ sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ach line. 23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause Approximate Intervel Between Onset end Deeth **Physician** Cardio Renal Vaseu /Medical Immediate Cause (Final 11054/evolic disease or condition resulting in deeth) Examiner Due to (or es e consequenca of) Examiner physician and the burial-transit The law requires that the death certificata be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in death) Lesl Due to (or es e consequence of) P.O. Box 68760 Physician/Medical Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by the should be detached 1 Yee 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to Completed 24a. Was en eutopsy completion of cause of death? has e 2 this certificate har ral director, page 1 ☐ Yes 2 ☐ No 1 Yes 2 LING To the Hospital or Attending Physician: I within 24 hours after death.

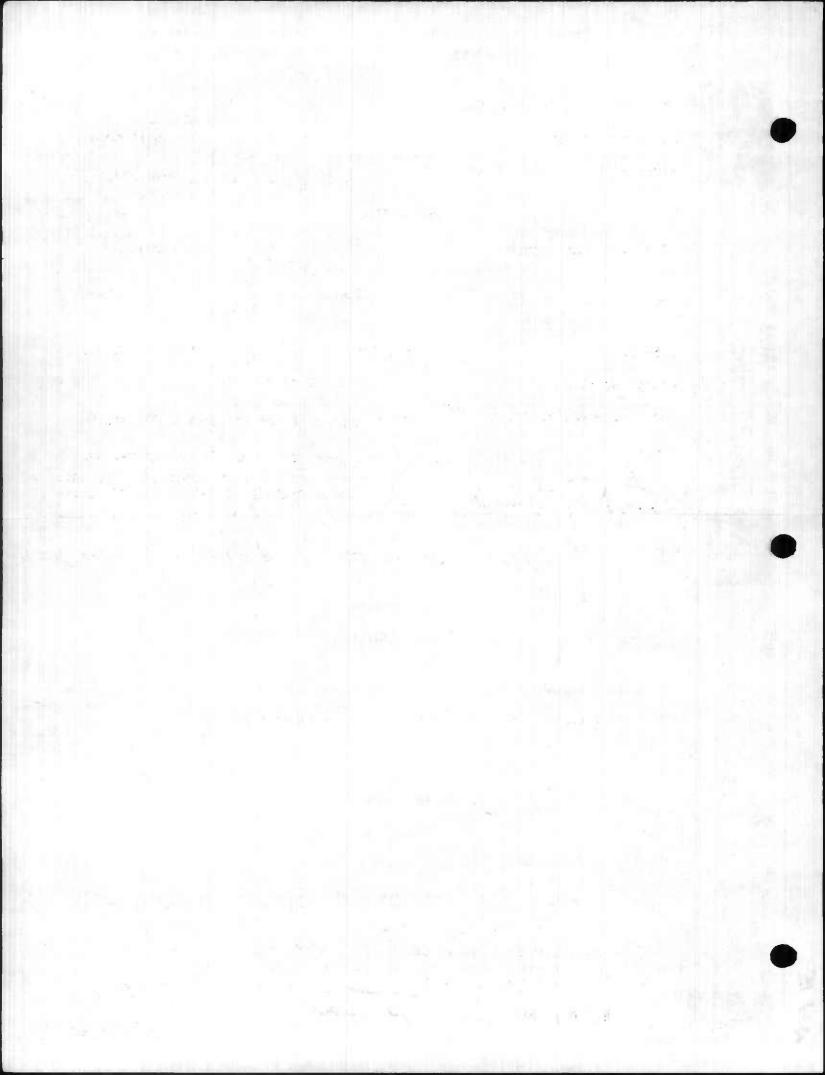
To the Funeral Director: After this certifica completaly filled in by the funeral director, p. Be 25. Was case referred to medical 26. Place of Deeth (Check only one) examiner2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Unpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 DNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) end manner as steted.

2 Description Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and manner stated. 29a. Certifier edical 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) harles onnell MI 31. Date filed (Month, Dey, Yeer) 32. Registrar's Signature State

**DHMH 16 Rev 6/95** 

Registrar

AUG 03



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔍 🔍 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 28 1999 11:15 AM MARGARET MARIE BERGER /Medical 4e. Facility Name (If not institution, give street and number)
Saint Joseph Medical Center 4b. City, Town, or Location of Death 4c. County of Death Baltimore **Examiner** If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🛣 F 130-12-1157 Yrs. Director Mar. 17, 1921 78 Germany Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits worde 7 is marked other than "naturel", or items 23a or 28a-f ehov traumstic event, tra Medical Exampler must be notified at Director 1 ☐ Yes 2 TNo Md. Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 205 Deep Dale Dr. 21093 USA Funeral 12. Was Decedent Ever In U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, atc. 11 Marital Status filed within 72 hours efter 1 Yas 2 No If Yes, Give Yaar or Dates: 1 ☐ Naver Married 2 ☐ Merrted Baltimore, Maryland 21215-0020 1 ☐ Yes 28 No Specify: White þ 3€ Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Department Manager Sears Co. 12 17. Fathar's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) Be Peges 1 end 2 should be nent of Health end Mentel I Maylahn Ida Augus Salzwedel 19a. Informant's Name/Retationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 i 205 Deep Dale Dr. Lutherville, Md. 21093 other t Mrs. Theresa Lioi/daughter 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State permit. Peges 1 Department of H Important: If Itel eny Injury or ott 1 Burial 2 Cramation 3 Remoyal from State 4 Donetion 5 Sothar (Specify) Entombment Druid Ridge Cemetery 7/30/99 Pikesville, Md. 22. Name and Address of Fecility Ruck Towson Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death **Physician** MUTIPLE ORGAN FAILURE DUE TO SEPSIS 12 DAYS /Medical Immediate Causa (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): SECONDARY TO PERFORATED GASTRIC ULCER bunal-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last end Due to (or as a consequence of): W/GENERALIZED PERITONITIS AND PNEUMONIA physician Box 68760. Physician/Medical the Due to (or as a consequence of) attending 980 ö P.O. Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. the 23b. Dld tobacco uee contributs to the cause of death? signed by the 2 No 3 Probably 4 Unknown 1 Yes Records, by 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy partormed? Completed peen : page 2 1 Yas 2 No 1 ☐ Yas No certificate Division of Vital Hospital or Attending Physician: Be 25. Was case raferred to medical 26. Place of Death (Check only one) examiner? Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 No 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: 28b. Tima of 28d. Describe how injury occurred After Naturet 5 Panding death. investigation 1 Yes 2 No 2 Accident Director: d in by the the 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 D Homicida Vithin 24 hours are To the Funeral Director Certifying Phyalcian: To the bast of my knowledge, death occurred at the time, date and place, and dua to the causa(s) and manner as stated. 29a. Certifier Medical ner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) D 26954

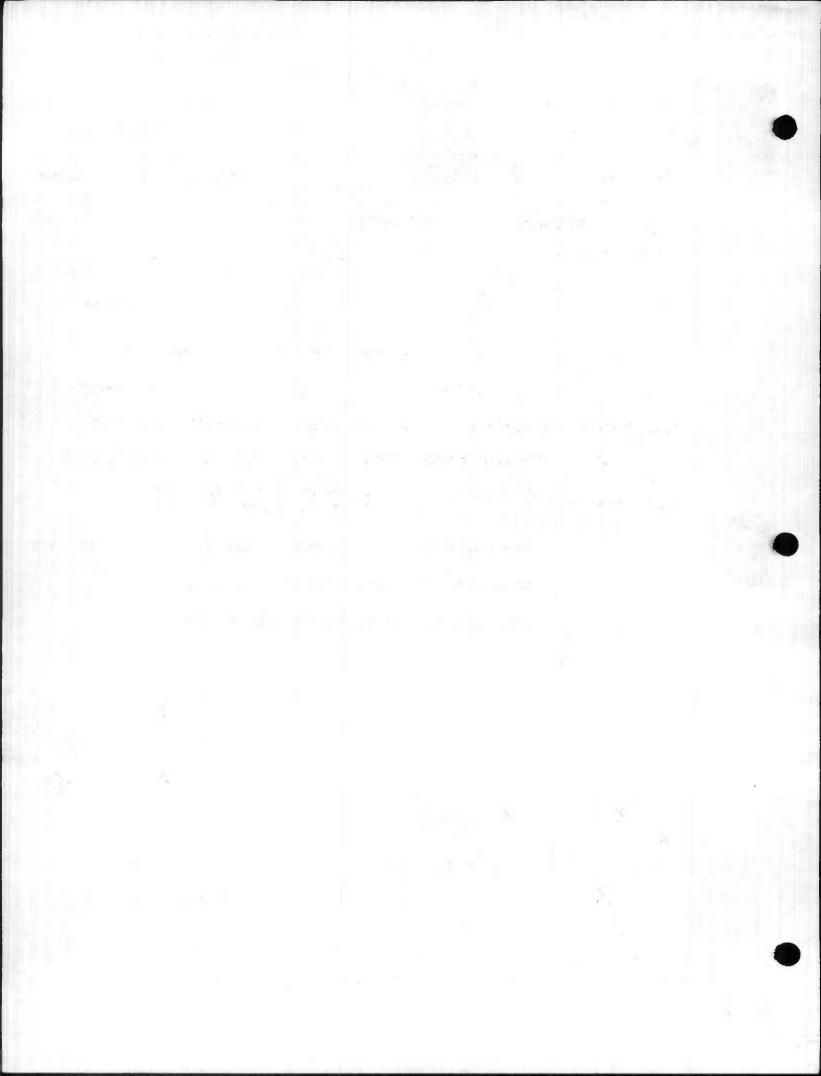
State Registrar 31. Date filed (Month, Day, Year) AUG 0 3 1999

32. Aagistrar's Signatura

30. Name and addrass of parson who complated causa of death (Item 23a) (Typa, Print)

boards

CHHIM M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

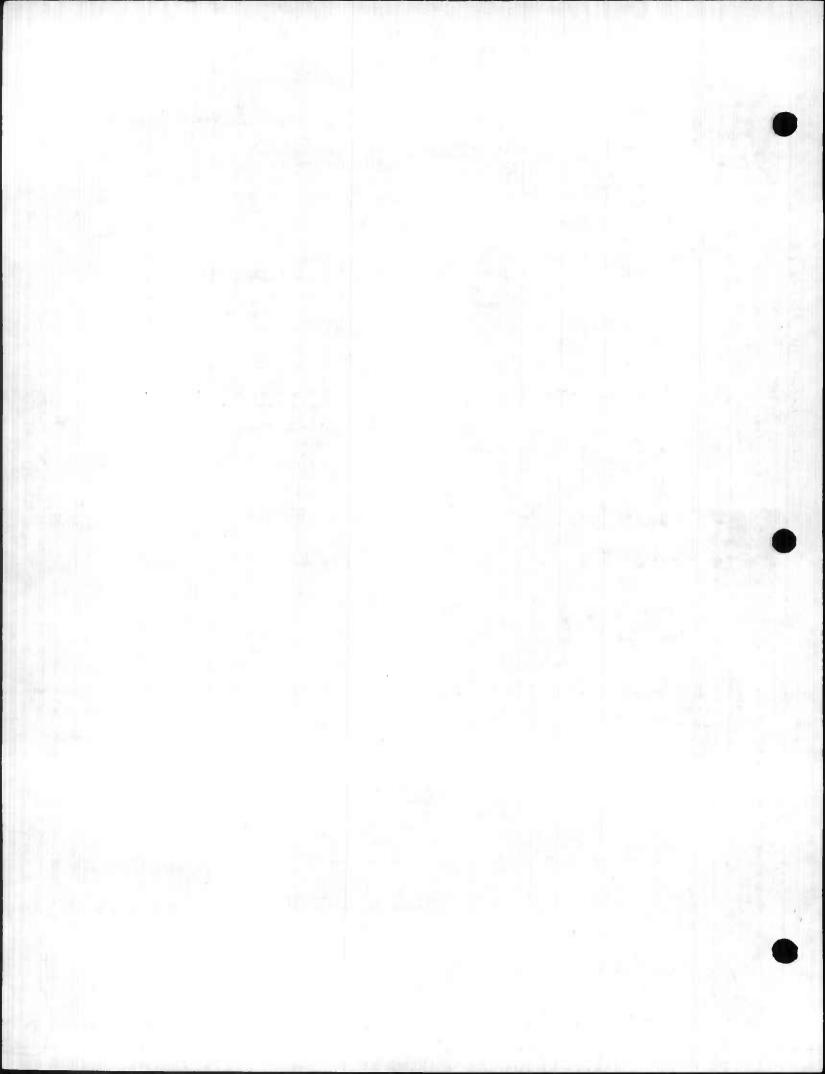
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Pauline Cardwell August 05:45 1999 /Medical 4s Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NA Sinai Hospital 04 Baltinore Baltinore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 204 F Months 86 Yrs. 410-42-1209 Director Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Heelth and Mental Hyglens. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Exercion must be notified at 2008. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pauline Card well 1 Yes 2 No Director Daltimore NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4800 Yellow wood Aue 21209 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Marital Status 1 Never Merried 2 Merried 21215-0020 1 Yes 2 No Specify: p Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Rivate 12+h Baltlmore, Maryland 17. Fsther's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Charles Shield CARMICHAR ANNIE 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dalto Md 20b. Place of Disposition (Name of Jemetery, crametory or other place) 29 21209 Daughter 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ABurial 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) laws Cenetera 8.5.99 Dalto 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 621 FUNGRAL 21215 4300 Wabash 23a. Pent. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Myocardial Inforction Examiner Due to (or als a consequence of): Examine arkry Coronary physician and the burial-transit The law requires that the deeth certificate be executed Sequentially list conditions, if sny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es s consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): signed by the a 0.0 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, ð 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? page 2 certificate has 1 ☐ Yes 2 ☑ No 1 Yes 2 No Division of Vital or Attanding Physician: 25. Wes case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) 1 Yes 2 No Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1) Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of tnjury (Month, Day Year) funeral 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 E Natural 5 Pending investigation deeth. 1 Yes 2 No 2 Accident 24 hours effer deet 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital Continue Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The property of the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier edical completely On the besis of exar and manner steted. (Check only To the To the F 29b. Signatupe 29c. License number 29d. Date signed (Month, Day, Year) D0053607 Hugust 1,1999 person who completed cause of death (Item 23a) (Type, Print) 30. Name and add Pa lanson, MD 7505 Osler 31. Date tiled (Month, Day, Year) 32. Registrar's Signature State Registrar AUG 0 3 1999

**DHMH 16 Rev 6/95** 

DS

Patient Known



#### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene LEE CHAPMAN Reg. No. 9 Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death Day Month **Physician** Lee F. Chapman JULY 30, 1999 12:47 AM /Medical 4a Facility Nama (# not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** JOHN HOPKINS BAYVIEW MEDICAL CENTER E.R. BALTIMORE If Under 1 Yaar | If Under 24 Hrs. 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) Birthplace (Steta or Foraign Country) **Funeral** Months Days 1 M 2□ F Hours 213-19-1956 20 Director 1978 11 MD Usual Rasidance of Decedant with the Manyland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow must be notified at MD N/A St. Helena 1 No Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 6510 Cleveland Ave USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Mexican, Puerlo Rican, atc.) Reme Was Decedent Ever in U.S. Armed Forcas? 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yas 2 XNo If Yas, Giva 1 ☐ Nevar Married 2 X Married 5 21215-0020 1 ☐ Yas 2 ☑ No Specify: by Specify: 3 ☐ Widowed 4 ☐ Divorced White natural Yaar or Datas: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elemantary/Secondary (0-12) College (1-4or 5+) Alarm Technician Electronics 12 and 2 should be file are to the file wit: If them 27 to marker ty or other 7 le marked other traumatic event, altimore. Maryland 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) Be Sandra B. Gerhart Daniel E. Chapman 19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 34 Township Rd Baltimore, MD 21222 /mother Sandra Hackman 20b. Place of Disposition (Nema of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 월 Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Department of Important: If any Injury or 1999 4 Donation 5 Other (Specify) Oak Lawn Cemetery Baltimore, MD <sup>22.</sup> Nama and Address of Facility
Connelly Funeral Home of Dundalk 21. Signatura of Funaral Sarvice Licenses 7110 Sollers Point Rd 21222 23a. Part f. Entar tha diseasa, or complications that caused tha dath. Do not antar tha mode of dying, such as cerdiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Intervel Between Onset and Death **Physician** /Medical Immediata Cause (Finel disease or condition rasulting in death) Examiner Physician/Medical Examiner the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of) Box 68760. Dua to (or as a consequance of): USB as P.O. 1 Part It. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by d be detact 1 Yes 2 No 3 Probably 4 Unknown Records, ð 24b. Wara autopsy findings available prior to completion of cause page 2 should Be Completed 24a. Was an autopsy completion of death 1 Yas 2 No 1 Yes 2 No certificate Division of Vital Hospital or Attending Physicien: director, 25. Was case rafarred to medical 26. Placa of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) edical Certification: To 1XXX as 2 No 1 ☐ Inpatiant XIX ER/Outpatient 3 ☐ DOA this 28d. Describe how injury filled in by the funeral 27. Mannar of Death 28a. Data of Injury 28b. Tima of Injury 28c. Injury at Work? perator After 5 Pending invastigation 1 Natural 30/ 1 Yas 2 No death. 0010 collides 2 Accidant To the Hospital or Attend within 24 hours after dealt To the Funeral Director: Piece of Injury - Af homa, building, atc. (Specify) 3 Suicide 6 Could not be At homa, farm, street, factory, office 28f. Location City or T (Str 4 Homicida 60 cen ast 1 Certifying Physician: To the best of myknowledge, deeth occurred at tha time, date end place, and due to the cause(s) and manner as stated.

\*\*Common Physician: To the best of myknowledge, deeth occurred at that time, date and place, and due to the cause(s) and manner stated.

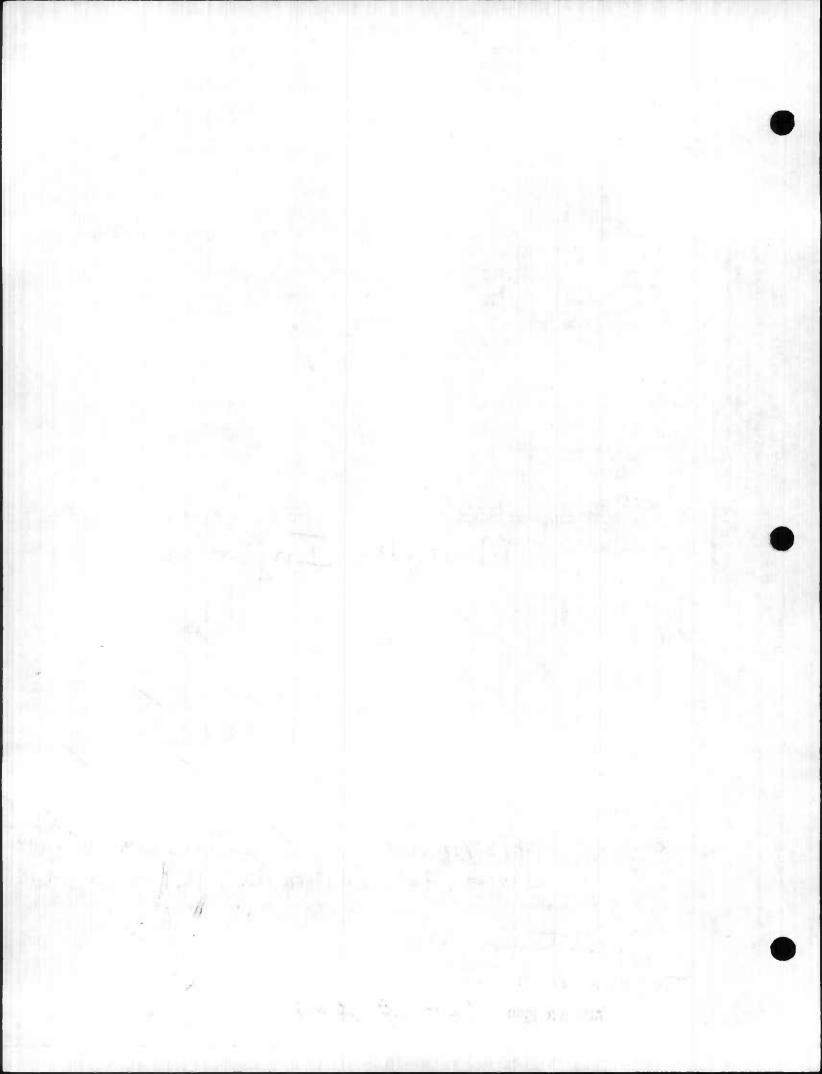
\*\*Common Physician: To the best of myknowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Cartifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) O.C.M.E JULY 30, 1999 ass of person who complated causa of death (Item 23a) (Type, Print)

OhreStoner 111 Penn S 8 30. Name and addi one 111 Penn Street, Baltimore, Maryland 21201 (Month Day, Year) 32. Registrar's Signature

State Registrar

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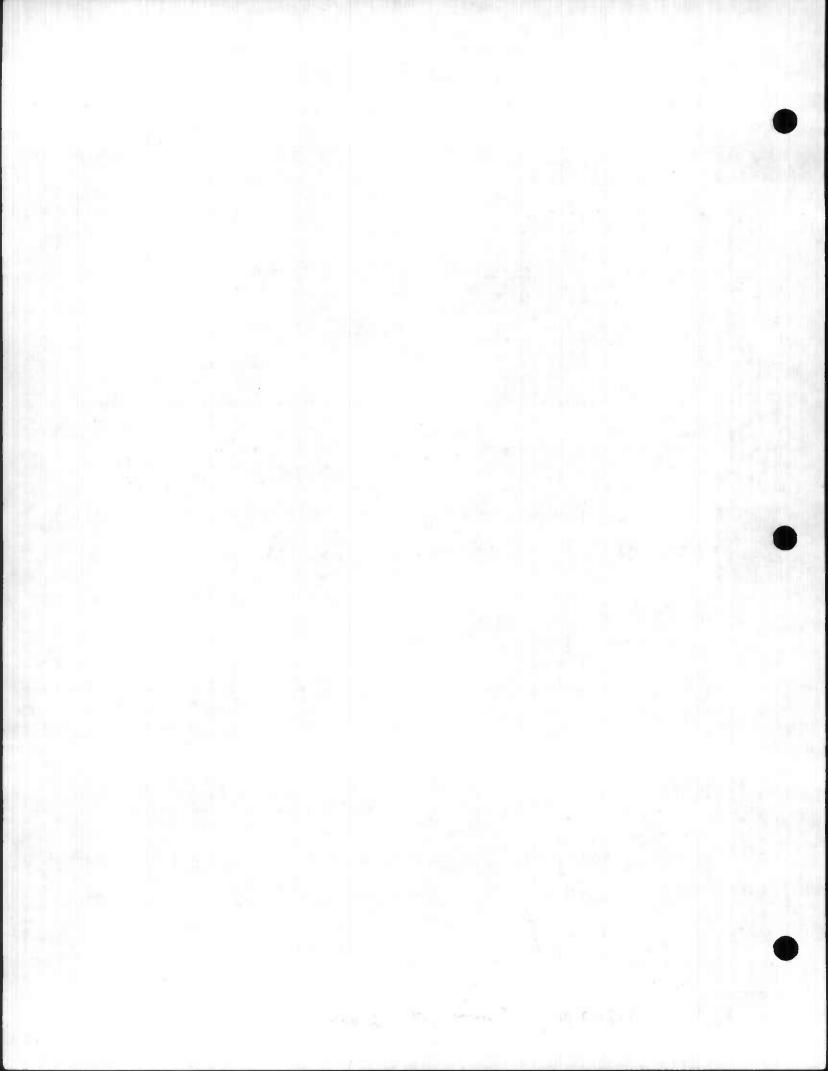


## Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Joan Μ. Chojnacki July 30 1999 10:24 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mercy Stella Maris Hospice Baltimore HUnder 24 Hrs. 8. De Hours Min. (A N/A If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Dale of Birth (Month, Day, Year) **Funeral** Months Days 1 M 2 F 62 Director 216-34-0710 MD May 28 Usual Residence of Decedent the Manyland 10a. State 10b. County 10c. City. Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notined at 10d. Inside City Limits MD Howard 1 ☐ Yes 2 No Director Colombia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5459 Blue Coat Lane 21045 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after Hygiene. Wher than "natural", or he 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2X No Specify: Specify: à 3 SWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Data entry clerk Accounting permit. Pages 1 and 2 should be file Department of Heelth and Mentel Hy important: If item 27 is marked other my injury or other traumatic avent phase. 17. Father's Name /First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 John Kolacz Caroline Perk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Orlando /daughter 7534 School Ave Baltimore, MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 M Cremetion 3 ☐ Removal from State Aug 3 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Catonsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility
Connelly Funeral Home of Dundalk C 7110 Sollers Point Rd 23a. Pert1. Enter the disease or complications that caused the death. We not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. Ust only one cause on each line. Approximate nterval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner physician and a the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): for use as 2 080 P.O. signed by the eld be detached f 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 No 3 Probably 4 Unknown Records, à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed s certificate has t 1 Yes 2 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physicien: "within 24 hours after death.

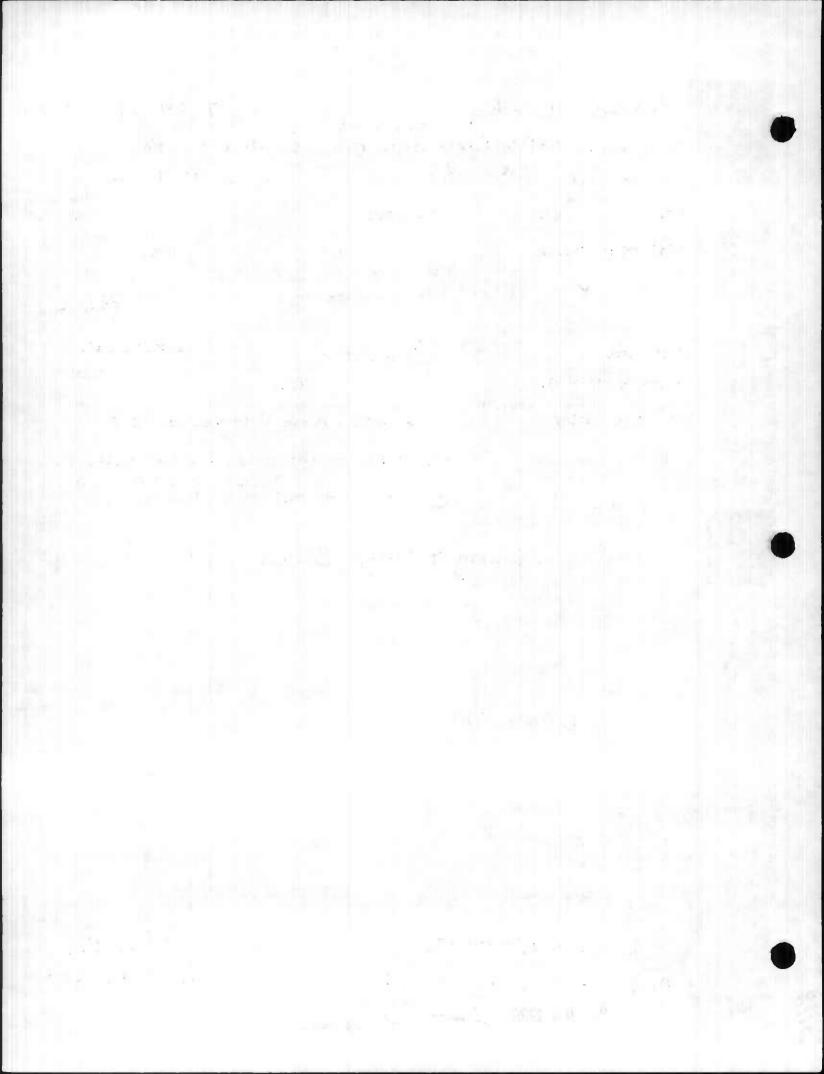
To the Funeral Director: After this certifica completely filled in by the funeral director; p 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Certification: To 1 npatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manng of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Matural 5 ☐ Pending investigation 1 TYes 2 No 2 C Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier to the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) In the basis of exa 29c. License number 29d. Date signed (Month, Day, Year) D42908 August 2, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Scharff, M.D. 808 S. Baltimore, MD Conkling St 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar AUG 0 3 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 24 81 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month De **Physician** leis 29 755 AM /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Rehab Hat. altimor Health + Rehab lennium iel Security Number n/a If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Deys 1 M 2 F Months Hours 218-22-3930 Usuel Residence of Decedent Yrs. -22-2934 Director -14 Md. with the Maryland 10e Stete 10b. County 10c. City, Town or Location show 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Md. n/a Baltimore Yes 2□No Director 10e. Street end Number 10f Zip Code 10g. Citizen of Whet Country? 1643 McKean Avenue 21217 USA Funeral death 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, 11 Maritel Status permit. Pages 1 and 2 should be filed within 72 hours effer a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or hand injury or other traumation. Bleck, White, etc. 1 Never Married 2 Merried Yes 2 No f Yes, Give X altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ ★ Specify: P 3 Widowed 4 Divorced Black Yeer or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Coilege (1-4or 5+) Private Families 12th Grade 18. Mother's Neme (First, Middle, Meiden Sumeme) unknown 17. Fether's Neme (First, Middle, Last) Be Theodore Blackwell Sadie 19e. Informent's Name/Reietionship (Type, Print) Husband 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) George H. Conley 1643 McKean Avenue Baltimore, Md. 21217 20b. Pieca of Disposition (Neme of cametery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Buriel 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) Garrison Forrest VeteransAug. 4 Owings Mills, Md. 22. Name end Address of Fecility Nutter Funeral Homes, Inc. 21. Signature of Funeral Service Licensee 2501 Gwynns Falls PKWY Baltimore, Md. 21216 nutter ٤ me 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feiture. List only one cause on each line. **Physician** /Medical Immediete Ceuse (Finel Cancer mediseese or condition resulting in deeth) **Examiner** Due to (or es e consequenca of): Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in death) Lest bunial-tran and Due to (or es e consequenca of): certificate be exec ettending physician for use as the buria Box 68760 Physiclan/Medical the Due to (or es e consequença of) P.O. ed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert i. 23b. Did tobacco uee contributa to the ceuse of death? 1 Yes 2 No 3 Probably 4 Unknown requires that signed t pmention Records, þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Wes en eutopsy Completed peen page 2 certificate hes 1 Yes 2 No 1 Yes 20 No Division of Vital director, 25. Wes case referred to medical Be 26. Piece of Deeth (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death Dete of Injury (Month, Dey Year) 28b. Time of Injury 28d. Describe how Injury occurred Certification: 28c. Injury et Work? After ! al or Attending P s efter death. I Director: After 5 Pending investigation 1. Naturel 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 Could not be determined 3 ☐ Sulcide 28e. Placa of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) filled in by 4 Homicide To the Hospital o within 24 hours of To the Funers! DI completely filled in Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the ceuse(s) end menner es stated.

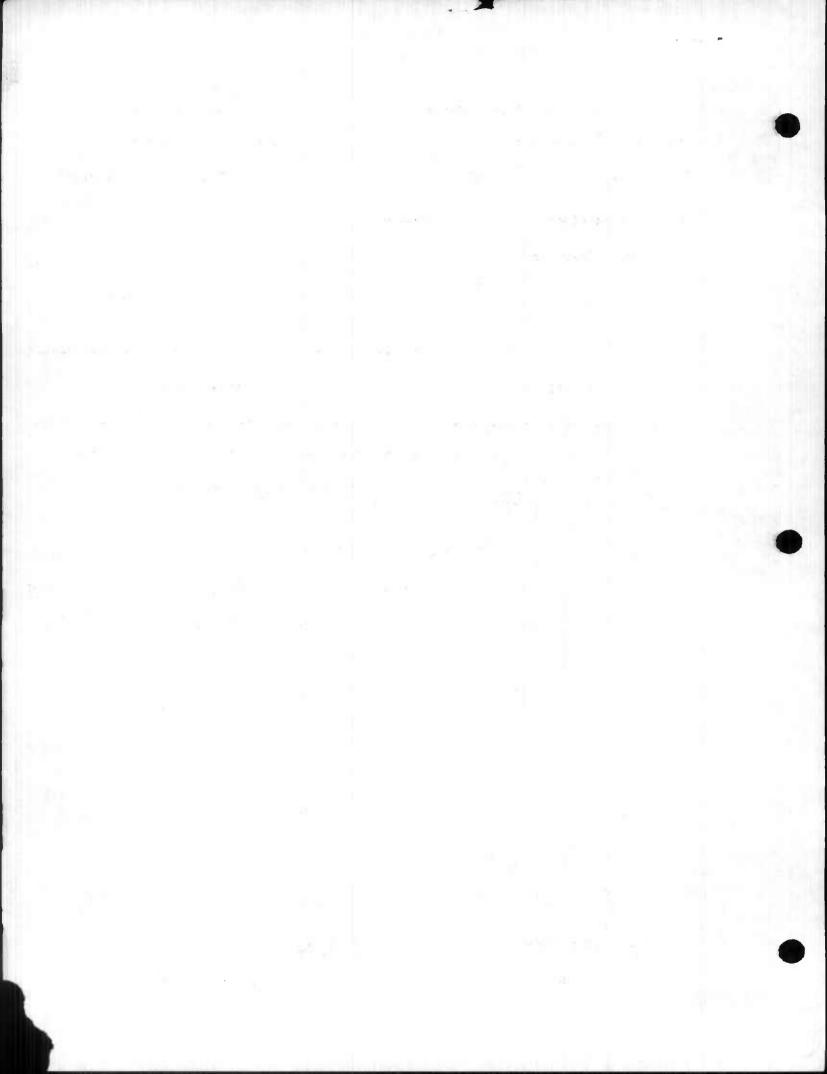
2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner stated. 29a. Certifier Medical (Check only one) 29b. Signeture end title of cartifier 29c. License number 29d. Date signed (Month. Dev. Year) ation N- Llacem MD 30. Name and address of person who completed cause of deeth (item 23e) (Type, Print) MAEEM AMATUN 31. Dete filed (Month, Day, Year) 32. Registrac's Signature State Registrar



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Division of Vital Records, P.O. Box 68760,

					Cert	ificate of	Death		Reg. No.		
		1. Decedent's Name (First, Middle, Last)						2. Data of De	ath		3. Time of Death
Physici /Medic		Margaret	Miller	Caner				July	20 1	999	2:55 PM
Examin		4a. Facility Name (If not institution, give		CHICL			4b. City, Town, or	Location of Death		unty of Death	
		Edenwald - Strou	Hall				Towson	1	Ba	altimor	~e
Funeral		Social Security Number     6. Security Number		e (In yrs. last	birthday)	If Under 1 Year Months Days	tf Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da			place (State or Foreign ntry)
Director		212-32-0978 Usual Residence of Decedent	М Ж.Г 9	6	Yrs.	Working Days	Tiours 1944.	6-7-19			ryland
how		10a. State 10b. County		10c. City, To	own or Loca	ation					10d. tnside City Limits
the Maryland r 28a-f show	ctor	Maryland Baltimore	9		Towso	n					1 ☐ Yes 2 ☐ No
or 28	Director	10e. Street end Number				10f. Zip Code			10g. Citizen	of What Cou	ntry?
death with ms 23a or must be		800 Southerly Ro	oad			21286			U.	S. A.	
after dea or items	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent i Armed Forces?				dispenic Origin? (S en, Mexican, Puert	pecify Yes or No o Rican, etc.)		Rece - Ameri Black, White,	etc.
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net net	Completed	15. Decedant's Edu (Specify only highest grade	cation com <i>pleted)</i>	10	(Give ki	nt's Usual Occup ind of work done	during most of wor	rking	16b. Kind	of Business/in	dustry
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2 should be filed with end Mental Hygiene, Is marked other the aumatic event, Itea	o Be		1								
should nd Men marka umaric	Ĕ	Edward C. Mil.  19a. tnformant's Name/Ralationship (Ty.		1	IQh Mailing	Address (Street	Mary and Number or Ru	Miller			n Code)
ges 1 and 2 should t of Health end Men If Item 27 Is merka or other traumetic		Julia C. Benefield 20a. Method of Disposition	1 (Daught	20b. Place	e of Disposi	tion (Name of		Dete		ion - City or T	and 21093 own, Stete
Pages nent of I nt: If ite		1 ☐ Burlal 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emovat from State			atory or other pla ervice (		7-31-99		,	
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		23a. Part 1. Enter the disease, or compli shock, or heart failure. List only on	cations that caused	the death. D							Approximate tnterval Between
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/Medical	П	Immediate Causa (Final disease or condition	No	LUTE	E	87720	CE			- 1	lo hours
Examiner		resulting In death)		Dua to (or as		ence of):	~1		_		
D ==	Examiner		Chre	hic	AT	RIAL	Fibr.	Mati	on	_ i	10 years
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physi the I	edicai	that Initiated events resulting in death) Last		Due to (or as	a conseque						
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atten for us	lan										
the d	Physician	Part II. Other algnificent conditions con	tributing to death bu	ut not resulting	g in the und	terlying cause give	ven in Part t.	23b. Dtd 1	lobacco uae		to the cause of death?
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been	Completed								med?	a\ cc	vallable prior to empletion of cause
The law ate has page 2	m								1/		death?
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lcian certif recto	Be	25. Was case raferred to medical examiner?	ospital:			O#	26. Place of Dea	ath (Check only o	ne)		
this al dir	2	I I tas 20 No	1 L Inpatie		Outpatient	3LI DOA	4 Nursing F	lome 5 Resid			fy)
ling I	lo	27. Manner of Death  1 Natural 5 ☐ Panding	28a. Date of Injur (Month, Day	Year)	b. Time of Injury	28c, Injui Wo M 1 □	rk?  Yes 2□No	28d. Describe I	now injury of	ccurred	
death death tor:	cat	2 Accident investigation 3 Suicide 6 Could not be	200 Place of this	ini. At home	form steed		1.62 5 140	29f Location /	Street and N	hum has as Pus	al Route Number,
of in by	Certification:	4 ☐ Homicida determined	28e. Place of trip building, ato	. (Specify)	, rarm, stree	at, ractory, ornica		City or Tox	vn, Stata)	diffiber of Hur	er Hodie raditiber,
To the Hospital or Attending Physicien: The within 24 hours elate death.  To the Funeral Director: After this certificate completely filled in by the funeral director, pag	-	29a. Cartifier 1 Certifytng Phys	tclan: To the best of	f my knowled	iga, daath c	occurred at the ti	ma, date and place	, and dua to tha	causa(s) and	d mannar as	stated.
the H tin 24 the Fu	ledica	one) / A	end manner sta	ted.	and/or inva						
S V V V	2	29b. Signature and taleful certifier	D			29c. Licens				igned (Month,	
		My	-			1234	1124		7-3	0-77	
}		30. Name and address of person who con	1 4 4 4	aath (ttam 23	a) (Type, P	rint)	1124 LUTHE	70	r 10.4	0 21	267
			Ito MD	12057	ackl	Ld#20	WITHE	ekviut	s, M	D 210	773
Stat	te	31. Date filed (Mooth Pay Year) 1990	3/2/49/80	nature	D.	sporks					



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Ce.	rtificate of		R	leg. No.	2	+183	
Physician	Decedent's Nama (First, Middla,	Last)				2. Data of Dea Month	th Day	Year	3. Time of Death	
/Medica	Henry Du	nton, Sr.				July	28,	99	12:55pm	
Examine	4s Facility Nama (If not institution, 1010 W. Bal		reet Apt.	#105	4b. City, Town, or Lo Balti		4c. County			
Funeral Director	216-34-0606	Sex 7. Ag	e (In yrs. last birthday) 62 Yrs.	If Under 1 Yaar Months Days		8. Data of Birth (Month, Day 02-14	. Year) -37	9. Birthpl Count M	ace (Stata or Foraign lry) D	
Pand Isand	Usual Residence of Decedent  10a. Stata  10b. County		10c. City, Town or Lo	ocation			144	10	Od. Inside City Limits	
death with the Manyland ms 23s or 28s-f show Frans be notified at	MD N	A	Baltimo	ore					XYas 2□No	
vith the Ma	10e. Street and Number	Apt	.#105	10f. Zip Code		1	Og. Citizen of W	/hat Count	try?	
ath w				2122:			USA			
Urs effect	1010 W . Bal 11. Marital Status 1 Nevar Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forcas? 1	No	Was Decedent of I If Yas, specify Cub 1 ☐ Yas 2 ☑ No	Hispanic Origin? (Sp en, Mexican, Puarto Specify:	ecify Yes or No- Rican, atc.)		e - Amarica k, Whita, a		
n 72 hours	15. Decedent's (Specify only highast	Education grada completed)	16a. Dece (Giva	dent's Usual Occu kind of work done	pation during most of work id)	ing	16b. Kind of Bu	sinass/Ind	ustry	
d 21215-0 filed within 72 ho Hygiena. ther than "naturn mt, for Modella.	Elementary/Secondary (0-12) 6th Grade	College (1-4or s		DONOT use retire	id)		Regel	Lau	ndry	
ind 2 tal Hygid d other avent, th	17. Father's Nama (First, Middla, La	st)	-		18. Mothar's Name	a (First, Middla,	Maiden Surnam	a)		
Aaryland 212. 2 should be filed within a and Mental Hygiens. Is marked other than reumatic event, the transfer of the transfer ovent, the transfer	William H	. Dunton			Irene		Murray			
■ 5章2章	19a. Informant's Name/Ralationship	nton	19b. Mailin 4422	ng Address (Stree 2 Marble	and Number or Aur e Hall R	oad Ap	t.#362	Stata, Zip Bal	<sub>Code)</sub> 21218 timore,MI	
Baltimore, semit. Pages 1 a. Mechanist of Hear moortant: if them into injury or other ance.	20a. Mathod of Disposition  **Burial 2 Cremation 3 4 Donation 5 Other (Spe		20b. Place of Dispo cematary, crea Western	natory or other pla	Cemetery		20c. Location - -99 Ca		wn, Stata ville, MD	
Balt permit Depart import any in	21. Signature of Funeral Service Lie	ensee CAL	/	Nama and Address  M. C. Ma	ass of Facility B arch FH			-	nd 21202 enue	
Physician /Medical	23a. Pact./ Entar the disease, or coshock, or heart failure. List or								Approximata Intarval Between Onset and Death	
Examiner	disaasa or condition rasulting in death)	a ATHERO	SCLEROT		DIOVAS	MLAR	DISET	tse,		
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W E D 3	resulting in death) Last  Dua to (or as a consequence of):									
death certiff e ettending	Part II Other algorificant condition	contributing to death h	ut not reculting in the u	adarbrina cauca ai	una in Rant I	22h Did to	phaces use cor	telbute to	the cause of death?	
ords, P.O. I requires that the desensioned by the should be detected it and by Physics	HYPERTEN	1	ributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of dear  1 Yes 2 No 3 Probably 4 Unknown		
aw requires to see a second se	TYPE Z	DIABET	ES M	526IT	us	24a. Was a perfor		ava	ira autopsy findings illable prior to inplation of cause death?	
The ison attention page 2						1 🗆 Y	as 2 No	1 🗆	Yas 213 No	
Of Vital I Physicien: The this certificate ral director, page Co					26. Placa of Deat	h (Check only or	na)			
Physic chis control of the control o		,	nt 2 EP/Outpatier	I 3LJ DOA		ma 5 Pasid			)	
C B ser	27. Manner of Death 1 Natural 5 Panding 2 Accident Invastigat		y Year) 28b. Time of Injury	Wo	ryat rk? ]Yas 2 □ No	28d. Describe h	ow injury occurr	ed		
Division and or Attances and or Attances and Director.  ed in by the Certifical	3 Suicida 6 Could no datamin	28a. Place of Injuding, etc.	ury - At homa, larm, str c. (Specify)	eet, lactory, office		28l. Location (S City or Town		er or Rura	l Routa Number,	
Divisio  To the Hospital or Attends within 24 hours after death. To the Funeral Director: A completely filled in by the t. Medical Certificati		Phyaician: To the best of aminer: On the besis of and manner sta	axamination and/or in	occurred at tha ti vestigation, in my	ma, data and place, opinion, daath occur	and dua to tha c red at tha tima, d	ausa(s) and ma lata and place, a	nnar as st and dua to	aled. tha cause(s)	
within Toth comp		nila	- 1	29c. Licen	se number		Ped. Data signed AUGU		Day, Year)	
	30. Name and addrass of person wh	o completed causa of d	eath (Item 23a) (Type,		0 - 1 6		1000	. > /	0,1999	
State	THOMAS S.  31. Data filed (Month, Day, Year)	MILLER 32. Registro	700 ar's Signatura	WASHI	NGTON	BLVD	RALT	0	MD 21230	
Registrar		1999	we G.	Spork	w :					

DHMH 16 Ray 6/95

VIRGIL DAUGHTRY

1. Decedent's Name (First, Middle, Last)

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99

Certificate of Death

2. Date of Death

Month

3. Time of Death

12:23 PM

	/Medical		Virgil Lee	Daughtry	JULY	31, 199	99 12.23 F			
	Examiner	4a Facility Name (If not Institution, git 4310 CARLEVIEW			4b. City, Town, or Location of D BALTIMORE					
	Funeral Director	228-50-3887	Sex 7. Age (In yrs	Ast birthday) If Under 1 Year Months Day	Hours Min. (Month	f Birth , Day, Year) 2-1930	9. Birthplace (State or Foreign Country)  N.C.			
	B	Usual Residence of Decedent  10a. State 10b, County	10c. C	ity, Town or Location		-	10d. inside City Limits			
	danyla f sho	Md N/A		ltimore			1 ☐ Yas 2 ☐ No			
	the line	10e. Street and Number		10g. Citizen of	What Country?					
with or	ifier death with the Mai r Items 23a or 28a-f si increment be notified Funeral Director	4310 Carleview F	Road	10f. Zip Code 21207	7		S A			
	ms 2	11. Marital Status	12. Was Decedent Ever in I		Hispanic Origin? (Specify Yes o ban, Mexican, Puerto Rican, etc.		ce - American Indian,			
21215-0020	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 X Yes 2 □ No If Yes, Give Year or Dates:	1 ☐ Yes 2 No			ck, White, etc. y: Black			
5-0	ed within 72 ho ygiene. for then "natural, ft, to the Completed	15. Decedent's E (Specify only highest gi	ducation rade completed)	16a. Decedent's Usual Occ (Give kind of work don life. DO NOT use retir	upation e during most of working		usiness/Industry			
121	S - S	Elementary/Secondary (0-12)	College (1-4or 5+)				ipbuilding			
	Hygiene. ther ther mt, the	9th grade 17. Father's Name (First, Middle, Las	N/A	Blue prin	18. Mother's Name (First, Mi	& Dry				
Maryland	Vario W	Robert Daughtry	,		Rosa Purvis		110)			
37	d 2 should be the and Mental T is merked of traumetic even To Be	19e. Informent's Name/Relationship	(Type, Print)	19b. Mailing Address (Street	et and Number or Rural Route N		, Stete, Zip Code)			
		Naomi Moore- S	Sister	4310 Carle		imore, Md				
Baltimore,	pemit. Pages 1 and Department of Health important: If Nem 27 any injury or other tr ance.	20a. Method of Disposition	20b.	Place of Disposition (Name of cemetery, crematory or other pl	Date		- City or Town, State			
E	Page ent o nt: H i	1) Burial 2 Cremation 3 (	Removal from State	arrison Forest		Owings	Mills, Md			
alti	permit. Page Department of important: If any injury or pace.	21. Signature of Funeral Service Lice		22. Name and Add	ress of Facility	Townings	M1115, MU			
0 385	P G P P P P P P P P P P P P P P P P P P	1 (Subrial	Da Ciak	March FA	H West ash Avenue Bal	timore, M	ld 21215			
	Physician /Medical Examiner	23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	. Sterio.		rele svigenla	Λ	Approximate Interval Between Onset and Death			
	axecuted in and istransit		h		And the					
	and and il-tran	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):							
60		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c							
68760,	death certificate be associted estending physician and of for use as the bunk-transit sician/Medical Examir	resulting in death) Last	Due to (	or as a consequence of):						
Box	nding use a		d							
	0 0 0	Part II. Other aignificant conditions	contributing to death but not re	sulting in the underlying cause of	riven in Part I. 23b.	Did tobacco una co	ontributa to the cause of death?			
, P.O	- 5ª E	Btron				1 Yan 2 No	3 Probably Unknown			
of Vitai Records,	w requires that been signed b should be deta leted by PI					Was an autopsy performed?	24b. Were autopsy findings available prior to			
000	The law requir rate has been s page 2 should Completed					SPECTION	completion of cause of death?			
æ	The is page page					1□ Yes XX No	t 🗆 Yes 2 🗆 No			
a	certificate rector, per Be Co	25. Was case referred to medical			26. Place of Death (Check o	nly one)				
7	Z 5 0	axaminer? XX Yes 2 No	Hospitei: 1 ☐ inpatient 2 ☐	ER/Outpatient 3□ DOA	ther: 4 ☐ Nursing Home XXI	Residence 6 DOt	her (Specify)			
	Attending Ph or death. ector: After th by the funeral	27. Manner of Death  12 Netural 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury M 1	ury at ork? 28d. Description 28d. Descri	ribe how injury occu	rred			
Division	8 4 X E	3 ☐ Suicide 6 ☐ Could not l 4 ☐ Homicide determined	28e. Plece of tnjury - At I building, etc. (Spec	nome, larm, street, lactory, officing)	28f. Locati City o	on (Street end Num r Town, Stete)	ber or Rural Route Number,			
	Hospi 4 hou Funer tely fill	1 Certifying P	hysician: To the best of my kn miner: On the basis of examin and manner stated.	owledge, death occurred et the ation and/or investigation, in my	time, date and place, and due to opinion, deeth occurred at the ti	the cause(s) and m me, date and place,	enner as stated. and due to the cause(s)			
	within 2 To the comple	29b Signature and title of centrier	8 . 0		nse number C.M.E		ed (Month, Day, Year) 2, 1999			

er or Rural Route Number, enner as stated. and due to the cause(s) d (Month, Day, Year) AUG. 2, 1999 npleted also of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)

AUG 0 3 1999

32. Registrar's Signature

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Samuel Di Pietro 01:30A 1999 August 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Geriatrics Center Baltimore City Johns Hopkins If Under 1 Year | If Under 24 Hrs. 8 Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) 1⊠M 2□F 217-32-7554 80 4-19-1919 Baltimore, Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits n/a Baltimore 1 Tyes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4940 Eastern Avenue 21224 USA 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1⊠ Never Married 2□ Married 1 Yes 2 No Specify: Specify: White 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2nd Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Gaetano DiPietro Anna D'Andrea 19a. Informant's Name/Relationship (Type, Print) sister 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Mrs. Lena Jansen 7044 Eastern Ave., Baltimore, Maryland 21224 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State Sacred Heart of Jesus 8/3/99 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph N. Zannino Jr, Funeral Hm. 263 S. Conkling Street, Baltimore, Md. 21224 23a. Part1. Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death Immediata Cause (Final disease or condition resulting in death) minutes volvalus with actectory and leastory SID moid Die to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 20 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Examiner sician and buriel-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician s the burie Physician/Medical .

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

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Completed

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**Funeral** 

Director

must be notifie

Nerns 23s or

natural', or

h and Mental Hygiene.
7 is marked other than "natural".
Itsumatic event, the Medical Exa

Pages 1 and 2 should be fill ment of Health and Mental H tant; if them 27 is marked off lury or other traumatic even

**Department** 

**Physician** /Medical

Examiner

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funeral director,

filled in by

completely

certificate

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After

deeth.

24 hours efter deet Funeral Director:

Vithin 2

or Attending Physician:

Hospital

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Completed

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Certification: To

Medical

death with the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0020

Box 68760.

Division of Vital Records, P.O.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

ITU

1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 1 Natural 5 Pending

investigation

28d. Describe how injury occurred 28c. Injury at Work?

1 Yes 2 No

6 Could not be 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

(Check only one) 29b. Signature and title of certified

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Day, Year) 29c. License number

to transport of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addre

Ctr. Baltimore MD

Kaf 31. Date filed (Month, Day, Year) State

2 Accident

3 Suicide

29a. Certifier

4 Homicide

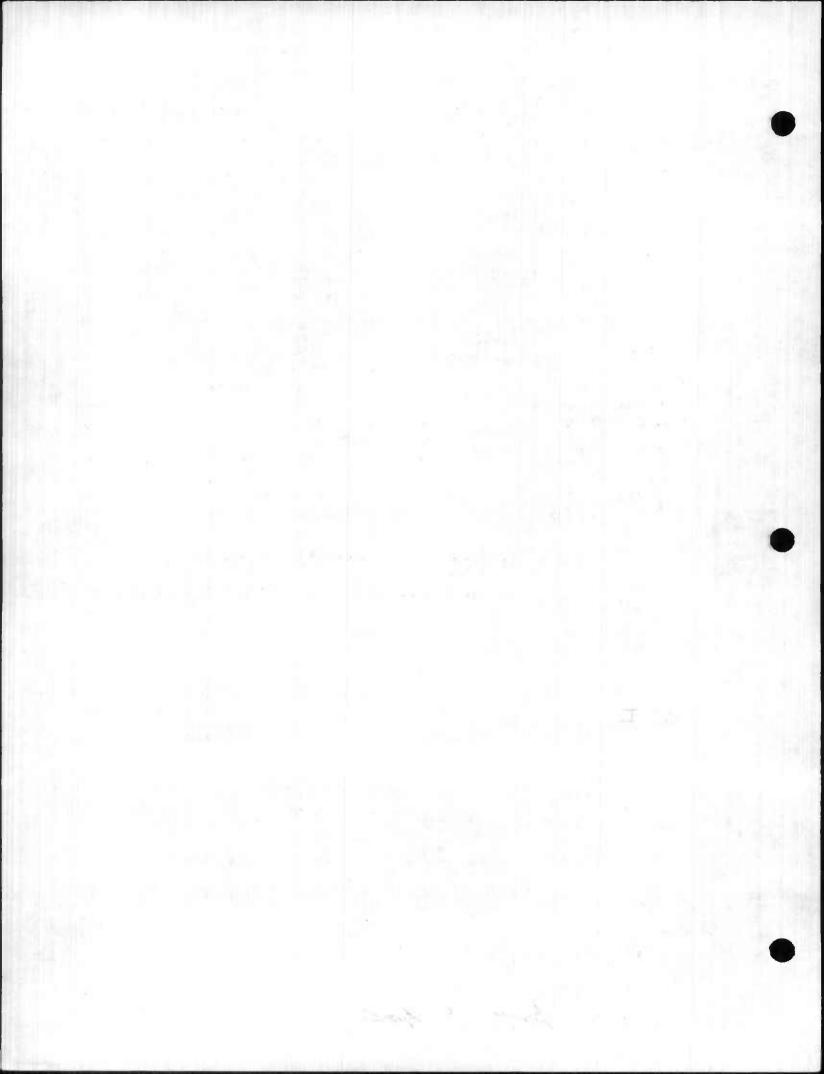
32. Registrer's Signature

4940

**DHMH 16 Rev 6/95** 

Registrar

Eastern



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Nama (First, Middla, Last) 3. Tima of Death 2. Data of Death Month Anna Dircks 4:10 AM 29 1999 July 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Mariner Health of Forest Hill Forest Hill Harford If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Data of Birth (Month, Day, Year) Birthplace (Stata or Foraign Country) Months Days 10 M 20 F 219-50-3155 Sept. 5,1907 Maryland Usual Rasidence of Deceden 10a Stata 10b. County 10c. City. Town or Location tOd. Insida City Limits Baltimore Maryland BaltimoreCounty 1 ☐ Yas 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 410 Carrollwood Rd. 21220 USA 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Waa Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian. Black, Whita, atc. 1 Yas 2 No If Yas, Giva A Year or Dates: 1 Nevar Married 2 Married 1□ Yes 2√ No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housekeeping - Own Home Housewife 5th grade 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Christian Dietz Katherine Hanf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Walter H. Dircks 9704 Gaylord St. White Marsh, Maryland 21162 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Data 20c. Location - City or Town, Stata NBurial 2 ☐ Cremation 3 ☐ Removal from Stata St. Michaels Ch. Cem. 7-31-1999 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Md. 21. Signature of Funaral Sarvice Licensee 22. Nama and Address of Facility 11750 Belair Rd. E. F. Lassahn Funeral Home assah Kingsville, Md. 21087 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death Immediata Causa (Finat disaasa or condition rasulting in death) 2 Hours Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury that initiated eventa resulting in death) Last Due to (or as a consequence of): Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown e 010 24b. Wara autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? 1 Yas 20 No 1 Yas 2 No 26. Place of Death (Check only ona) Hospitat: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Mursing Homa 5 Rasidance 6 Other (Specify) 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28h Time of 28c. Injury at Work?

Examiner ician and burial-transit physician as the burial signed by 2 peen has

Box 68760

Division of Vital Records. P.O.

Physician/Medical Completed Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifical. Be Certification:

**Physician** 

/Medical

Examiner

Directo

Funeral

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Completed

88

**Funeral** 

Director

280-1

than "natural", or liams 23s or 28s-1 the Medical Examiner must be notifi-

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed Department of Health and Mental Hygil Important: If item 27 is marked other

**Physician** 

/Medical

2

edical

29a. Certifier (Check only one)

25. Waa casa refarred to medical axaminer? 1 Yas 2 No 27. Manner of Death

1 Naturat 5 Pending investigation 2 Accident 3 Suicide

6 Could not be detarmined 4 Homicide

28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

1 Tyes 2 No

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 1 Certifying Physician: To tha best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and manner as stated

29b. Signatura and titla of certifier

AUG 0 3 1999

Whiam 41) 29c. License number D 32609.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Data signed (Month, Day, Year) 7 30114

Havre De Grauno 21078

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

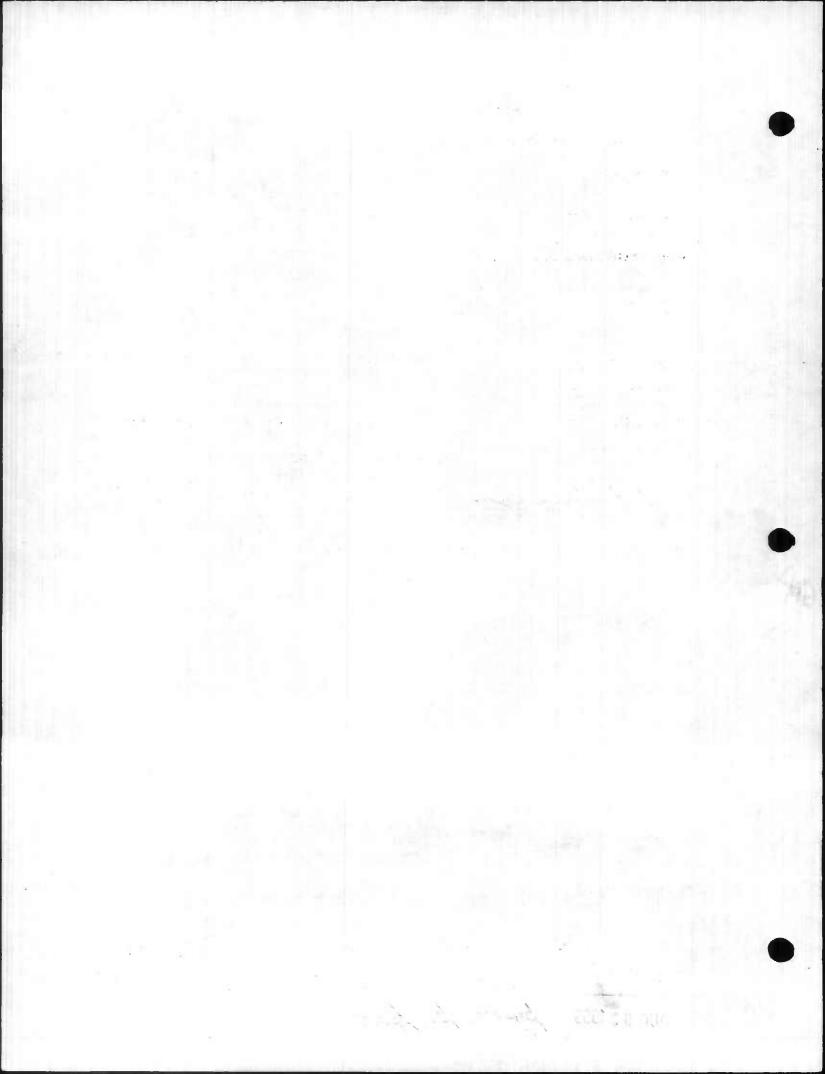
MO Metham K am melin

32. Registrar's Signature

Revolution St.

State Registrar

Within 2.



The law requires that the death certificate be executed physicien end s the buriel-transit Division of Vital Records, P.O. Box 68760. 98 ettending p been signed by the should be deteched certificate hes t director, page 2 s or Attending Physician: director, this funeral After death. Director: A within 24 hours after To the Funeral Dire completely filled in b the Hospital To the within 2 To the

**Physician** 

/Medical

Examiner

**Funeral** 

Director

"natural", or items 23a or 28a-f show social Examiner must be notified at

Peges 1 end 2 should be filed within 72 hours after death with end of Health and Mentel Hyglene.

nt: if item 27 is marked other than natural; or items 23s or iny or other traumatic event, me Media.

permit. Peges 1 and 2 s Department of Health ar Important: if Item 27 is any Injury or other trau

**Physician** /Medical

Examiner

Examiner

Physician/Medical

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Completed

Be

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Certification:

edical

29a. Certifier

(Check only one)

31. Dete filed (Month

29b. Signeture end title of certifier

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

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the Marylend

State Registrar atson MD 32. Registrer's Signeture

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

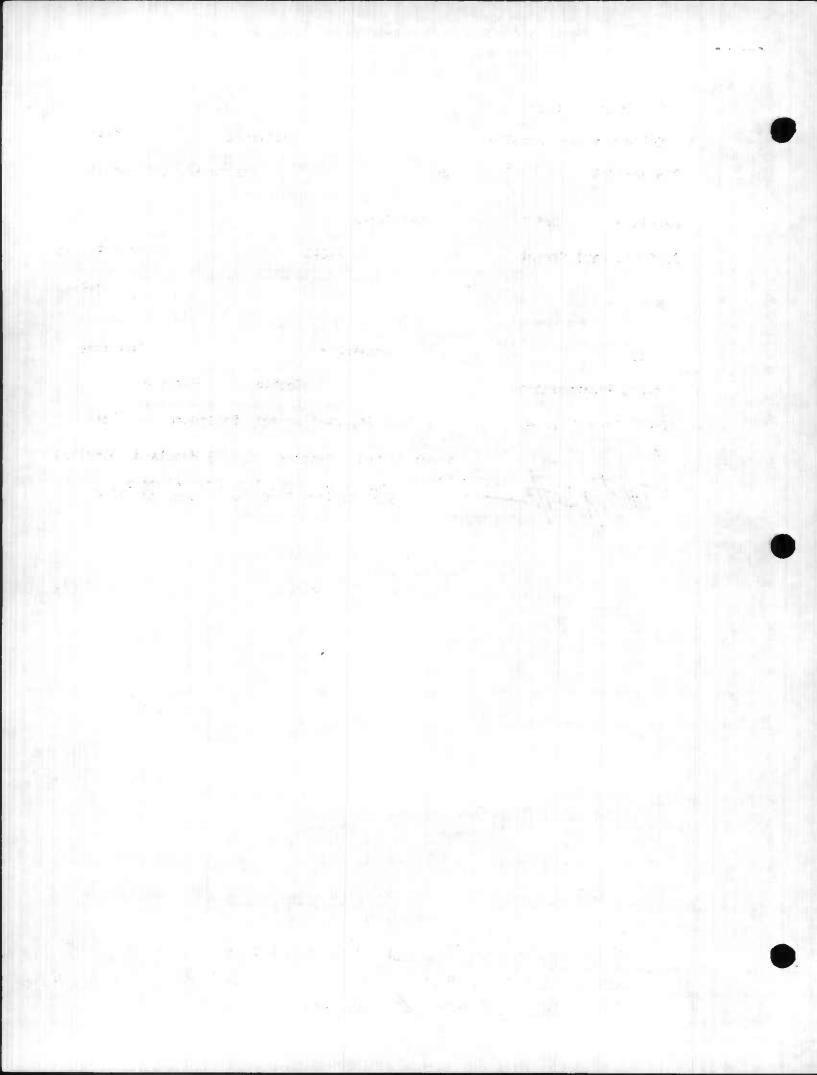
2018. University PKuy UMH

1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated.

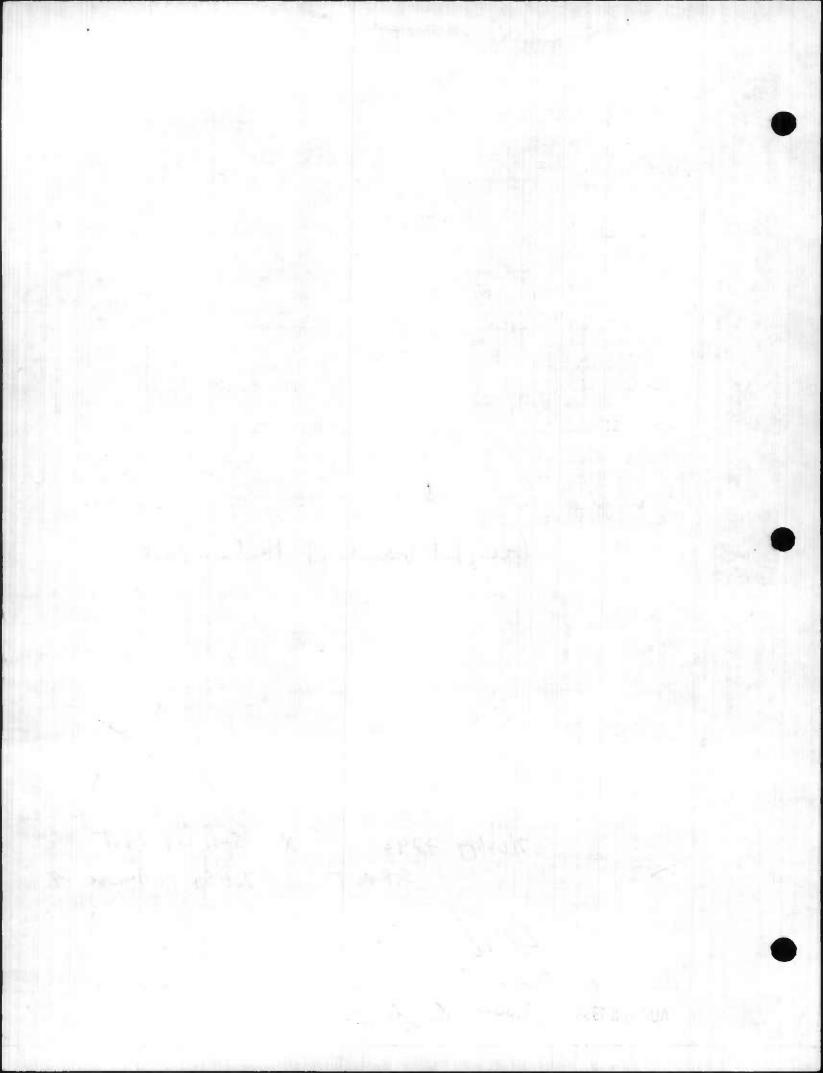
29c License number

29d. Date signed (Month, Dey, Year)



# Piease Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

	1 Decedent's Na	ma /First Mide	flo ( act)					Death	2. Date of D	Reg. No.		12:	Tima of Death
ysician	1. Decedent a Name (First, Middle, Last)  CHARLES ELBECK							Month	Day	Yea	ır		
Medical	4a Facility Name	4 - 40		d number)				4b. City, Town, or	JULY Location of Dea	28	1999 ounty of De		252
aminer			ONROE ST							40.0	ounty or be	oau i	
	5. Social Security		6. Sex		ge (In yrs. las	t birthday)	If Under 1 Year	BALT IMO If Under 24 Hrs		irth	9.6	Richolace	/State or Foreig
eral ctor	219-74-81 Usual Residenca	243	10LM 20		40	Yrs.	Months Days	Hours Min.	8. Dete of B (Month, D	-1958		Country) MD	(State or Foreig
Director	10a. Stata	10b. Count	у		10c. City, 7	Town or Loc	ation				700	10d. In	side City Limit
Director	MD				BALT	IMORE						1	Yes 2□N
Sire or	10e. Street and N	umber					10f. Zip Code			10g. Citize	n of Whet (	Country?	
la la	5100 GO	DDNOW R	COAD				21206			u.s	.A.		
by Funeral	11. Marital Status 1 Never Ma 3 Widowed		rried 1 1	Decedent of Forces? res 2(1) s, Give or Dates:			as Decedent of H Yes, specify Cub. ☐ Yes 2 (X) No	dispanic Origin? (S an, Mexican, Puer Specify:	pecify Yes or No Rican, etc.)		Black, Williams		dian,
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event, the Medical	Elementary/Sec		T	ge (1-4or :	5+)	life. D	O NOT use retire	during most of wo d)					
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o B	STERL	ING ELB	ECK					ALICE	FIRECK				
T	19e. Informant's I	Name/Relation	ship (Type, Print)	)		19b. Mailing	Address (Street	and Number or Ri		ber, City or	Town, State	e, Zip Code	9)
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othe	20a. Method of Di				20b. Plac	e of Dispos	GOODNOW ition (Name of	KU. BALL	IMORE M	20c. Loca	ation - City	or Town, S	State
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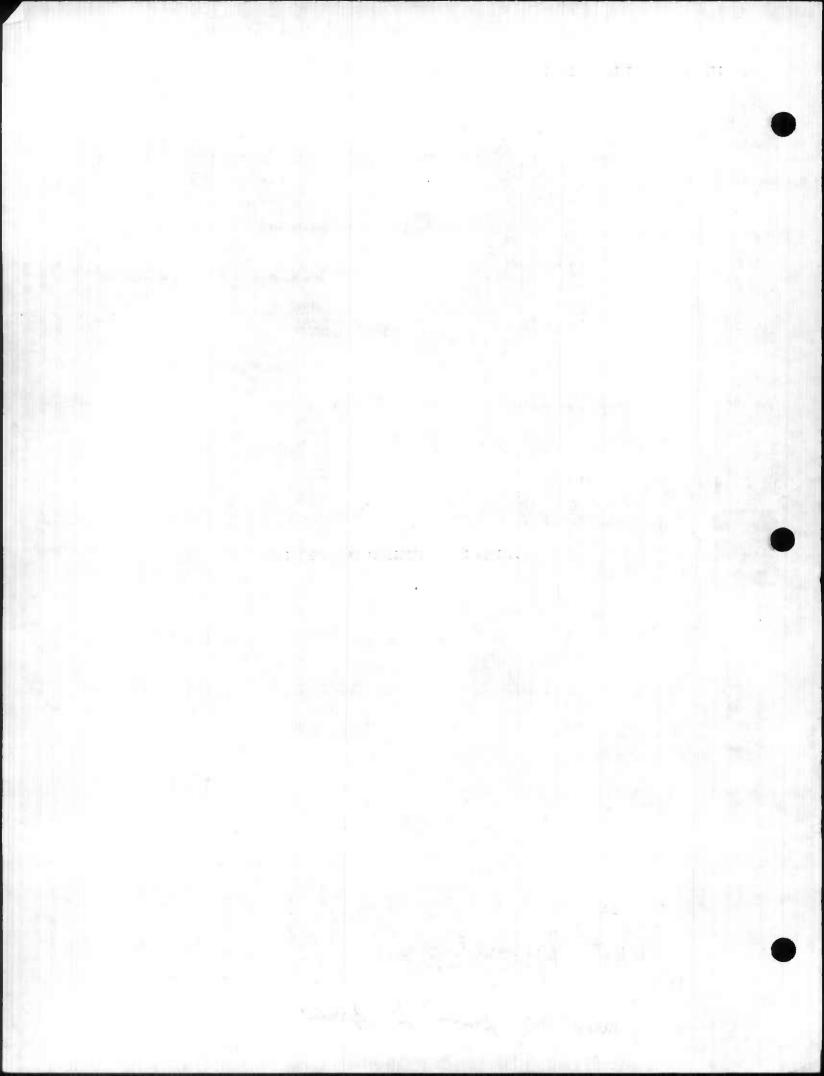


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F	KEITH EVAN	Clate	f Maryland /				ind M	ental Hyg	iene 9	24	189	)
	AMEND ITEMS  Physician	: #23 PART I, 27 PER MEO G774 8  1. Decedent's Name (First, Middle, Last)		Certific	ate of	Death		2. Data of Deal Month	eg. No.	Year	3. Tima d	
Š,	/Medical	Keith 4a Facility Name (If not institution, give street and nur	Gregory	Evans		4b. City. To	wn. or Lo	JULY cation of Death		999	205	5 PM
	Examiner	3301 DORITHAN ROAD APAR				BALT						
	Funeral Director	5. Social Security Number  UN L  Usual Rasidence of Decedent	7. Age (In yrs. last I	Yrs. If U	hs Days	If Under 2 Hours	Min.	8. Data of Birth (Month, Day, 7-21-	1953	9. Birthp Coun	laca (Stata try) Md	or Foreign
	anyland ahow dat	10a. Stafe 10b. County		own or Location						1	Od. fnside (	City Limits
	the Media	Md N/A	Baltir		Zip Code			11	0g. Citizen of V	What Coun		s 2 No
	23a or	3301 Dorithan Road			2124	4			US		,	
020	filed within 72 hours after death with the Meryland Hygiene.  the than "natural", or itama 23a or 28a-f show ent, the Medical Examiner must be notified at e.Completed by Funeral Director		2 No		ecedent of H specify Cubs s 2 No		gin? (Spe , Puarto f	cify Yas or No- Rican, etc.)	Bla	ce - Americ ck, White, y: Bla	atc.	
21215-0020	ed within 72 ho ygiene. or than "natura it, the tendral I	15. Decedant's Education (Specify only highast grade completed)	16	Sa. Decedent's t	Jsual Occup work dona	eation during most	of working	ng	16b. Kind of B	usiness/Inc	lustry	-
2121	in then the transfer ompl	Elamantary/Secondary (0-12) Collega (1 11th grade N/A	-4or 5+)		ng As		nce		Hospi	tal		
	tiel Hyge died other avent,	17. Father's Nama (First, Middle, Last)				18. Motha	r's Nama	(First, Middle, N				
Maryland	2 should be and Mental Is marked of summit av	Major Evans  19a. Informant's Name/Relationship (Type, Print)	140	Ob Mailing Add	rans (Streat	Julia		SON Routa Number,	City or Town	Crate 7in	Codel	
	1 and 2 shot Health and Health and arm 27 ls myther treum	Julia & Major Evans- Pa		3429 Me		Drive		timore,			0000)	
Baltimore,	Titan r	20a. Mathod of Disposition  \$\times \text{\text{Burial}} 2 \subseteq Cramation 3 \subseteq Removal from 1.	come	of Disposition (	Name of or other place	ce)	1		20c. Location			
Itim	pemit. Peg Department Important: I any Injury o	4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee	King	Memori	al Pai			30-99	Randal	lstow	n, Md	
Ba	Depart Depart Import any Inje	Alada wa	1.2	Mar	ch F/I		st	ue Ral	timore	d	21215	
		23a. Part1. Enter the disease, or complications that c shock, or heart failure. List only one cause on a	ausad the death. Deach line.							. , .	Approxima Intarval Be	ata etween
	Physician /Medical	Immediata Causa (Final	OCO TAMALINION	FEICIENCY	CANDDO	/ 2	\				Onset and	Death
	Examiner	diseasa or condition resulting in death)  ACQUIT	RED IMMUNODE Due to (or as	a consequance		ME (AIE	05)					
	n end ial-transit	b								i i		
,092	eath certificate be executed attending physician end for use as the burial-transit clan/Medical Examir	Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Causa (Disease or Injury that initiated events		a consequance								Ta,
Box 68	requires that the death certificate seen signed by the attending phy hould be detached for use as the eted by Physician/Media	resulting in death) Last	Dua to (or as a	a consequance	or):							
O. B	the att the att	Part II. Other algniffcant conditions contributing to de	eath but not resulting	In the underlyi	ng causa giv	en in Part I.		23b. Dld to	bacco usa co	entribute to	the cause	of death?
, P.O.	igned by the a libe detached find by Physic							1 🗆 Ye	es 2□ No	3 Prol	oably 4	Miknown
Records,	The law requires that has been sign page 2 should by Completed b							24a. Was ar perform		ava	are autopsy ailable prior mpletion of death?	r lo
E E	ysician: The law is certificate has b director, page 2 s								is 2 No	10	Yas 2	□ No
Z Z	Physician: The ribis certificate oral director, pag.	25. Was casa rafarred to medical axaminar?  **Coxyes 2 No Hospitel: 1   1		2.4.4.4	DOA Oth	A.C.		(Check only on			COP	NIT?
Division of Vital	2 2 3	27. Mannar of Death 28a. Data of	npatiant 2 ER/0 of Injury h, Day Year) 28b	Tima of Injury	28c. Injur Wor		2	na 5 Reside 8d. Describe ho	-		SCE	NE
Divisi	tal or Attending P rs after death. el Director: After t led in by the funer: Certification:	3 Suicida 6 Could not be	of Injury - At homa, ng, atc. (Specify)	farm, street, fac	ctory, office		2	8f. Location (St. City or Town	reet and Numi n, Stata)	ber or Rura	l Routa Nu	mber,
	To the Hospital or A within 24 hours after To the Funeral Direc completely filled in b. Medical Certifi	29a. Cartifiar (Check only one) 1 Cartifying Physician: To the \$75 Medical Examiner: On the be and many	isis of axaminetion a	ge, deeth occur and/or invastige	red at the tin tion, in my o	na, date and pinion, deat	d place, a h occurre	nd dua to tha ca d at the time, da	ause(s) and ma ate and place,	annar as si end due to	ated. tha cause	(s)
	To the Tour Community of the William	29b. Signature and title of contilier he Yh	ul	pin	29c. Licens	e number C.M.E.		25	9d. Data signe JULY	28,		
		30. Nema and address of person who completed caus:  HARYAMTO A. KOC	LEW 111 1	Penn St	reet,	Balti	more	, Maryla	and 212	201		
	State Registrar	31. Data filed (Month, Day, Year) 32. Rd	egistrads Signature	B	Sport	es						
		AUG U 3 1999	Carpor .	1-1	1	- 4						

DHMH 16 Ray 6/95



# VOID CERTIFICATE # 99-24/190

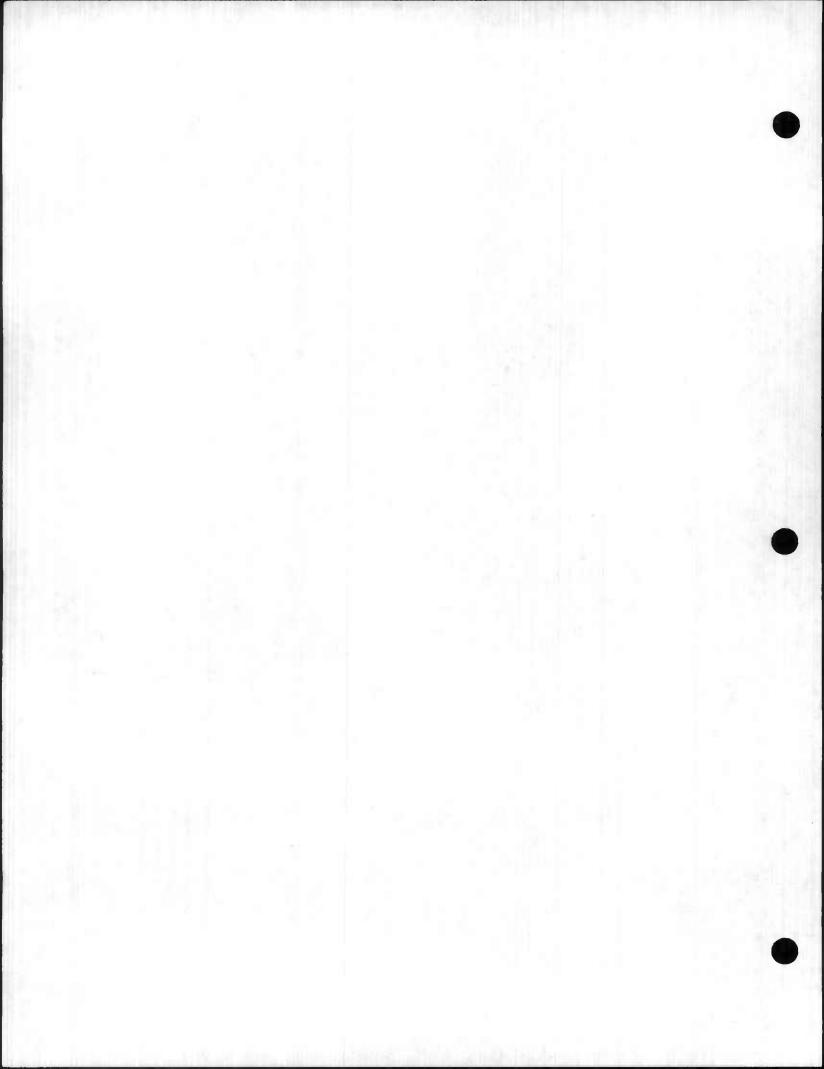
SEE

CERTIFICATE M

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NUMBERED. OVER A 498-PRE-EXISTING NUMBER

> 98-36960 AIREADY FILED



WRC 99-4517-005 FREDERICK F.

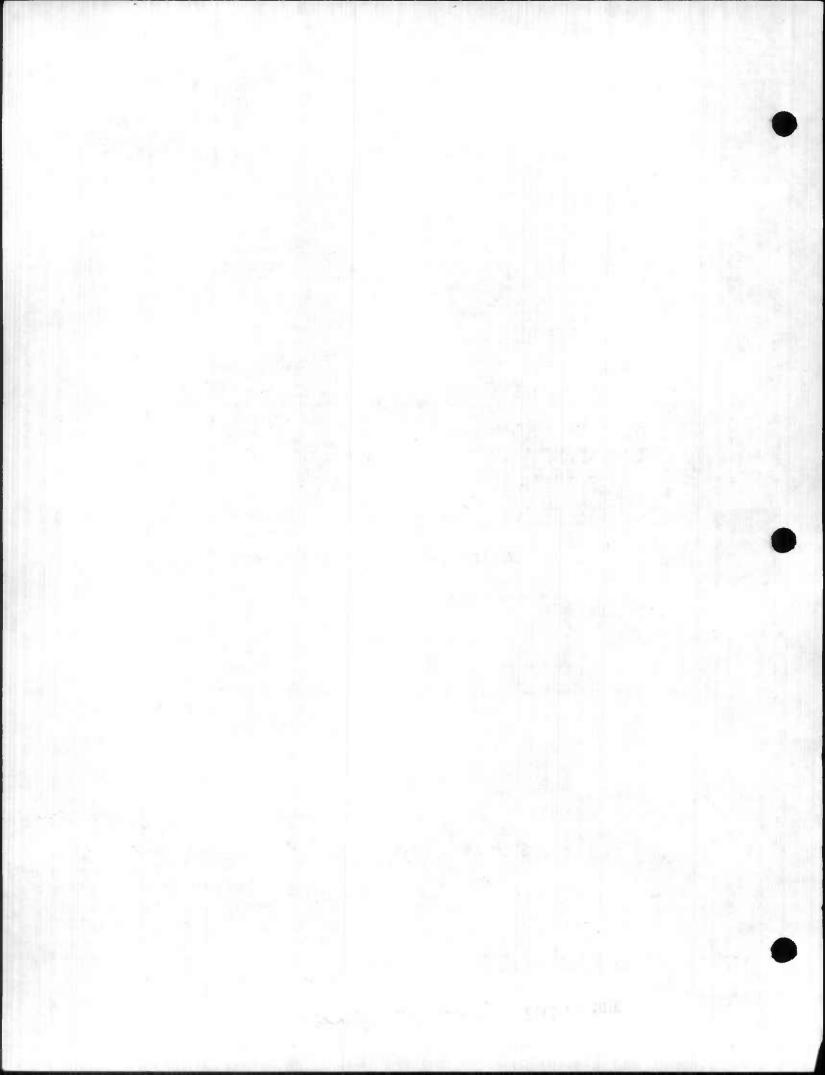
## Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

EBERT		,	Cen	tificate of	Death	R	eg. No.	24	191
	1. Decedent's Neme (First, Middle, Las	st)				2. Dete of Deat			. Time of Death
Physician /Medical	Frederick	F. Eber	t Jr			AUG. 01	, 1999	Yeer	6:25 PM.
Examiner	4e Fecility Neme (If not institution, give			4b. City, Town, or L	ocation of Deeth	4c. County of Death			
	3103 DUNDALK A	AVE.			DUNDALK		Balt	imore	
Funeral Director	5. Social Security Number  213-62-3260  Usual Residence of Decedent	ex 7. Age (In ⊠ M 2□ F	yrs. last birthday) 41 Yrs.	Months Days	Hours Min.	8. Dete of Birth (Month, Day, May 31	Year)	9. Birthplece Country) MD	(State or Foreign
Pu Man	10a. Stete 10b. County	100	. City, Town or Loc	ation				10d.	Inside City Limits
or 28s-1 sh to notified Director	MD Baltimo	ore	Dundalk	1					1 ☐ Yas 2 ☑ No
Vith I	10e. Street and Number			10f. Zip Code		1	0g. Citizen of V	What Country?	
a 23	3103 Dundalk		-110 40 1	21222		- '' V N	USA	e - American I	- dian
Baltimore, Maryland 21215-0020  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, its Medical Eminites must be notified at page.  To Be Completed by Funeral Director	11. Meritel Stetus  1 Never Merried 2 Merried  3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces?  1 Yes 22 No If Yes, Give Yeer or Detes:		Yes, specify Cub  ☐ Yes 2 ☑ No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Bled	white, etc.	
I 21215-0020 ed within 72 hours at yglene. ner than "natural", or it, the Wedler Error. Completed by F	15. Decedent's Ed (Specify only highest grad Elementery/Secondary (0-12)		(Give k	ent's Usual Occup ind of work done O NOT use retire	during most of work	sing	16b. Kind of Bu	usiness/Indust	гу
and 2121 be filed within tal Hyglene. d other than event, the Me	12	O011090 (1 -101 01)	Store	e Manac	ger		Auto	Glass	
Be doth	17. Fathar's Neme (First, Middle, Last)				18. Mother's Nem	e (First, Middle, I	Maiden Sumem	10)	
aryla should the nd Ment marked umartice	Frederick F. I	Ebert Sr.			Franc	es Mroz	inski		
Maryland d 2 should be file th and Mental Hy T Is marked othe traumatic event	19e. Informent's Neme/Reletionship (7		19b. Meiling	Address (Street	and Number or Rur	ral Route Number	, City or Town,	Stete, Zip Co.	de)
e, N 1 and 1 Health Health Wher tr	Denise Ebert	/wife			alk Ave	Balti	more,	MD 2	1222
altimore, mit. Pages 1 ar pertant: If them 2 y Injury or other ca.	20a. Method of Disposition 1 ⊠ Burial 2 □ Cremetion 3 □			atory or other pla	ce) A	1	20c. Location -	City or Town,	State
Iting Parity Plants	4 Donetion 5 Other (Specify		St. Sta			ug 7	Baltin	nore,	MD
Balti permit. Departm Importa any Inju	21. Signeture of Funerel Service Licensee  22. Name end Address of Fecility Connelly Funeral Home of Dundalk 7110 Sollers Point Rd 21222								2
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a. Intra	-oral to (or as a consequ		net wo	rund			set and Deeth
owoused in and risk-transit Examiner		b	. /	anna afti				i	
figile be executs physician and s the burishmen delical Exam	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due	to (or as a consequ	rence or):				1	
BS / BU, tilicate be expo or physician an as the burisk-th	thet initiated events	c. Due 1	o (or as e consequ	ence of):					
- 2 P	resulting in death) Last		,	,				i	
Box saft cert for use		d						1	
at the death ce d by the attends weached for use Physician	Part It. Other significant conditions co	entributing to death but not	resulting in the un	derlying cause gi	ven in Pert I.	23b. Dld to	bacco use co	ntributs to the	cause of death?
						1 🗆 Y	es 2Mo	3 Probabi	y 4 Unknown
Hecords, he law requires to s has been signed age 2 should be ompleted by						24e. Wes a perform	n autopsy	24b. Wera e availab	autopsy findings ble prior to
The law requir state has been a page 2 should Completed						Limi	. /	of dear	etion of cause
						1,2(Ye	s 2 No	1200	s 2 No
VITAL stellen: Th certificats medor, pa	25. Wes case referred to medical examiner?				26. Place of Deat	th (Check only on	(8)		A.F.
Physician: This certific ral director	Y Yes 2 No	Hospitel: 1 Inpatient	2 ER/Outpatient	3□ DOA Oth	her: 4 Nursing Ho	ome 5 Reside	enca 6 🕅 Oth	er (Specify)	SCENE
Attending r death. sctor: Ahe by the luns iffication	27. Menner of Death  1 Neturel 2 Accident  3 Suicide 4 Homicide	0 1 17	1800 At home, ferm, stre		Yes 2 XNo	c., b.l.	. Describe how injury occurred		
Cer led Only			idence			Baltimore	c Coun		cyland
To the Hospital or within 24 hours afte To the Funeral Oir completely filled in Medical Cert	29e. Cartifier (Check only one)  1 Certifying Phy XXMedical Exami	reiclen: To the best of my Iner: On the basis of exam and manner stated.	knowledge, death ninetion and/or inve	occurred et the til estigation, in my o	me, date end place, opinion, deeth occur	end due to the ca red at the time, do	ause(s) and ma ete and place,	inner as state and due to the	d. ceuse(s)
and to the state of the state o	29b. Signeture and title of certifier	1	,	29c. Licens			9d. Date signe		, Year)
10%	Styph &	Vlade	7,MP		D.C.M.E.		AUG. 02	1999	
1.0	30. Name and address of person who c	ompleted cause of death			Baltimon	ne Marro	land 21	201	
State	31. Dete filed (Month, Day, Year)	2. Registrar's S		· DULCCU,	, LALCHIO	Lo, Taury.	IURI ZI		

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Registrar



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** July 29,1999 Margaret Evering 8:00 am /Medicai 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 1021 Chesaco Ave. Rosedale Baltimore 5. Social Security Number 216–10–7976 7. Age (In yrs. last birthday) 88 Yrs. If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1□M 2X F Days Director 10-23-10 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show MD **Baltimore** Rosedale 1 ☐ Yes 2 🗓 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1021 Chesaco Ave. 21237 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ₺ No If Yas, Give Yeer or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11. Maritai Status permit. Pages 1 and 2 should be filed within 72 hours effer of Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or iter any injury or other traumetic event, the Medical Examine Opce. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: white 312 Widowed 4 □ Divorcad 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles J. Horner Sr. Catherine Fischer 19a. Informant's Name/Retationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Restivo / daughter 1021 Chesaco Ave. Rosedale, MD 20b. Place of Disposition (Name of cemetery, crematory or other placa)
Most Holy Redeemer 20c. Location - City or Town, State 1 XBurial 2 Cremetion 3 Removal from State 8-2-99 Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Cvach/Rosedale Funeral Home 21. Signature of Funeral Service Licensee 1211 Chesaco Ave. Rosedale, MD 23a. Part1. Entar the diseasa, or complications that caused the death. Do not entar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onsat and Death **Physician** /Medical Immediata Causa (Final CARDIAC ANNEST

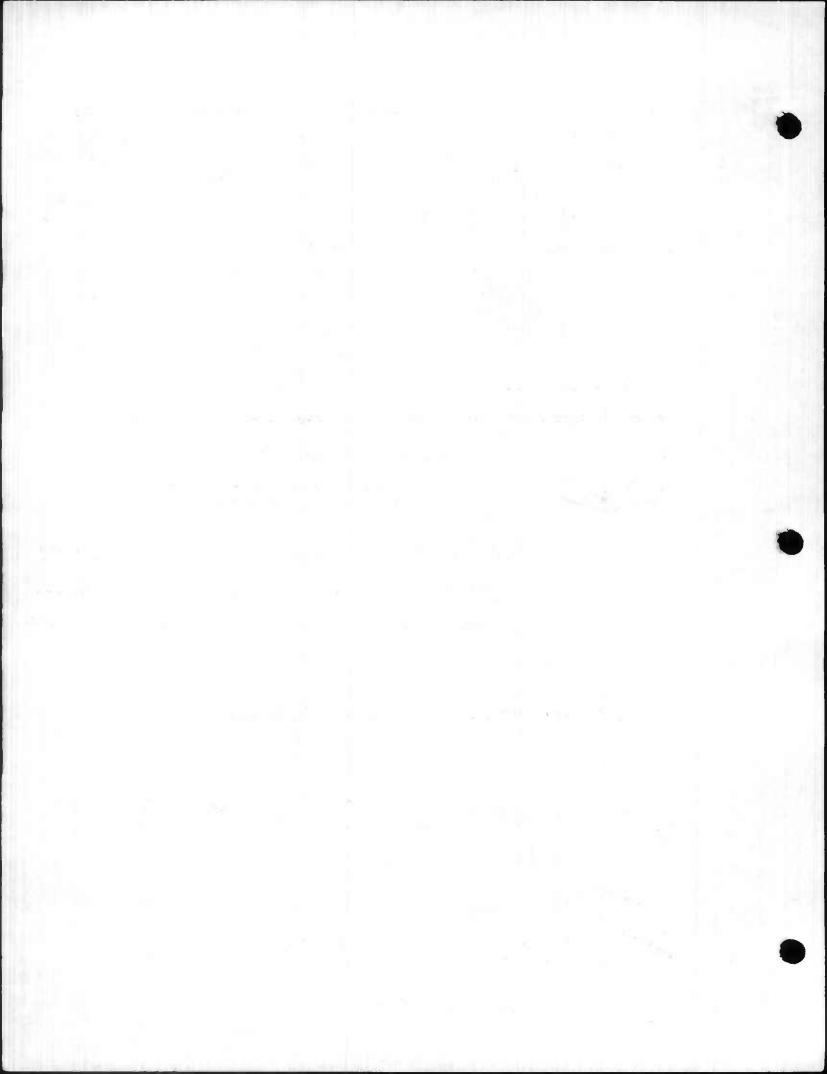
Due to (or as a consequence of): disease or condition resulting in death) Examiner Physician/Medical Examiner Due to (or as a consequence of): ician and buriel-transit Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Diseese or Injury that Initiated evants resulting in death) Last INSULIN DEDENDENT DIAKAGE physician s the buriel Box 68760. Due to (or as a consequenca of) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? METASTATIC MICIGNANT MELANOMA 1 Yes 2 No 3 Probably 4 Unknown signed b Records, ò 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificete Division of Vital To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifice completely filled in by the funeral director, p. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Rasidenca 6 ☐ Other (Specify) 28c. Injury at Work? 27. Mannes of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 1 Natural 5 Panding 1 Yes 2 No Investigation 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 D Homicide Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Modes Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at tha time, data end placa, and due to the cause(s) and manner stated. 29b. Signature and little of certifie 29c, License number 29d. Data signed (Month, Day, Year) 007/32 30. Name and address of person who complated causa of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signatura State

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Registrar

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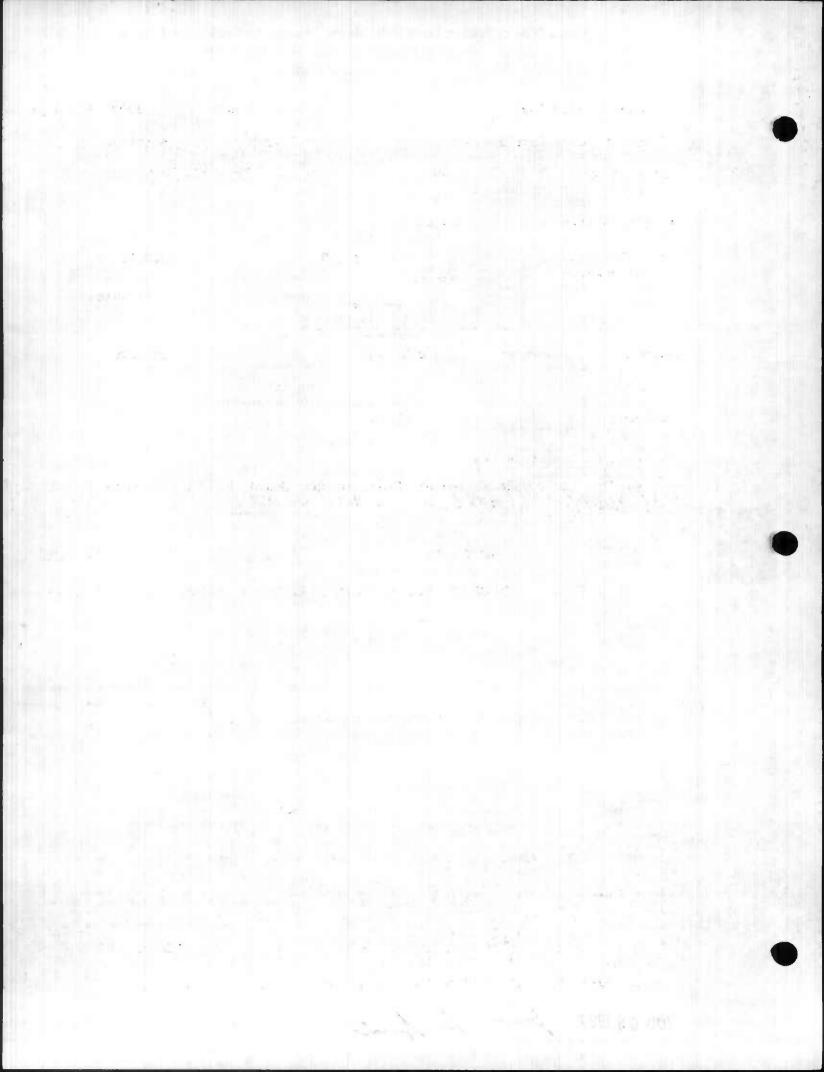


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Certificate of Death 1 Decedent's Nama (First Middle Last) 2 Data of Death 3. Time of Death **Physician** Andrew Filkohazi June 5 1999 12:30 pm /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner Franklin Woods Nursing Home Baltimore Baltimore If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) If Undar 1 Yaar 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** 150 M 2□ F Months Days Yrs. 48 Director 154-03-5139 Nov. 19, 1950 unknown Usual Rasidance of Dacedan the Maryland 10a. Stata 10c. City, Town or Location 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Modical Example: must be nothed at 10b. County 10d Inside City Limits 1 Yas 2 No Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 3 Maple Drive Funerai 21220 U.S.A. 14. Race - American Indian, Black, Whita, atc. death 12. Was Decedant Evar in U.S. Armed Forcas? UNKNOWN 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status unknown filed within 72 hours efter 1 ☐ Navar Marriad 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced unknown Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa ratired) 15. Decedant's Education 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7; Department of Health end Mental Hygiene. Important: If Item 27 is marked other than "na any Injury or other traumatic event, the Media page. (Specify only highest grada completed) Elamentary/Secondary (0-12) Coilega (1-4or 5+) unknown unknown unknown unknown 17. Fathar's Nama (First, Middla, Last) 18. Mother's Neme (First, Middle, Maldan Surnama) Be unknown unknown 19b. Mailing Addrass (Streat and Number or Rural Routa Number, City or Town, State, Zip Code) 19a, Informant's Nama/Relationship (Type, Print) unknown 20b. Placa of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramovai from State 4 □ Donation 5 ③Othar (Specify) in state 21. Signature of Furreral Sarvice Licensee 22. Nama and Addrass of Facility Ronald s. rector State Anatomy Board, 655 W. Baltimore Street Baltimore, MD 21201 Ether tha disaard, or complications that causad tha death. Do not anter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one ceuse on each line. Approximata ervel Between Onsat and Death **Physician** Immadiata Causa (Final disaasa or condition resulting in death) /Medical LUNG CANCER 12 MTHS Examiner Due to (or es a consequance of): Examiner CHRONIC OBSTRUCTIVE PULMONARY DISEASE 8 YEARS physicien and the burial-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): Box 68760 Physiclan/Medical Dua to (or as a consequence of). 981 P.O. 23b. Did tobacco use contributa to the cause of death? the a be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by Yes 2 No 3 Probably 4 Unknown Division of Vital Records. by 24b. Wara autopsy findings available prior to complation of cause of death? Completed 24a. Was an autopsy Deen certificate has 2 No 1 Yas 1 ☐ Yas 2 ☐ No 25. Was casa refarred to medical exeminer? 26. Placa of Death (Check only one) Be 1 Yas 200No Hospital: Othar: 4 Suspensing Homa 5 Rasidence 6 Othar (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Deta of Injury (Month, Day Year) funeral 27. Mannar of Death 28c. Injury at Work? 28b. Tima of 28d. Dascribe how injury occurred Certification: After 5 Pending Invastigation 1 Matural death. 1 ☐ Yas 2 ☐ No 2 Accident or Attendation of the death 6 Could not ba datamined 3 Suicida 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicide Hospital 24 hours Descritifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) end menner as steted.

Medical Examiner: On the basis of exemination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Cartifiar edlcai (Check only one) To the To the To the 29b. Signatura and titla of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) D.O. H35593 JULY 29,1999 30. Nama and address of person who completed causa of death (Item 23a) (Type, Print) LOH 1129 MACE AVE., BALTIMORE. MD. 21221 DR. JOHN J. 31. Data filad (Month, Dey, Year) 32. Registrar's Signetura

State Registrar

p. Spars.



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 🔾 🔾 AMENDED ITEM #1 PER MD G774 8/3/99 AH Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death GRACE GRACE ELIZABETH SMITH ASMUS FONES **Physician** 12:55 JUL 30 1999 /Medical 4a Facility Name (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE HOSPITAL GOOD SAMARITAN If Undar 1 Yaar | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** Days 1□M 2ØF Yrs. 81 **Director** 079-10-8805 Usual Residence of Decedent Apr 8 1918 New York the Marviand 10a Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits itam 27 le marked other than "natural", or hams 23a or 28a-f ahor other traumatic evant, the Medical Examinar must be notified at 1 Vas 2 □ No Directo N/A Baltimore City Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 353 D Homeland Southway 21212 USA death 12. Was Decedent Ever in U,S.
Armed Forces?
1 Yas 2 No
If Yes, Give
Year or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, atc. 11 Maritai Status 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: þ Specify: 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Dietician Hospital 4 yrs permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked other any injury or other traumatic evant. 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 0 Charles Baird Smith Elizabeth Broadhead Clyne 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6433 Blenheim Road, Baltimore, Maryland 21212 Mr. Mark Stuart Asmus (Son) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/31/99 Baltimore, Maryland Green Mount Crematory 22. Name and Address of Facility Martin B. Lawson awson Mitchell-Wiedefeld Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

Approvis Approximate interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical CARDIO PULMONARY Examiner ACUTE MYOCARDIAL Examiner INFARCTION physician and s the burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury ORONARY ARTERY P.O. Box 68760 Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of) USB BS Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ATRIAL FIBRILLATION ģ CEREBRO VASCULAR ACCIDENT 24b. Wera autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 ☐ Yes 2 No 1 Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred Attending 1 Natural 5 Panding investigation death. 1 Tyes 2 No 2 Accident after death Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 07,30,1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOCH RAVEN BOULEVARD, BALTIMORE, MD 21239-2995 GOOD SAMARITAN HOSPITAL, 5601 32 Registrar's Signature

**DHMH 16 Rev 6/95** 

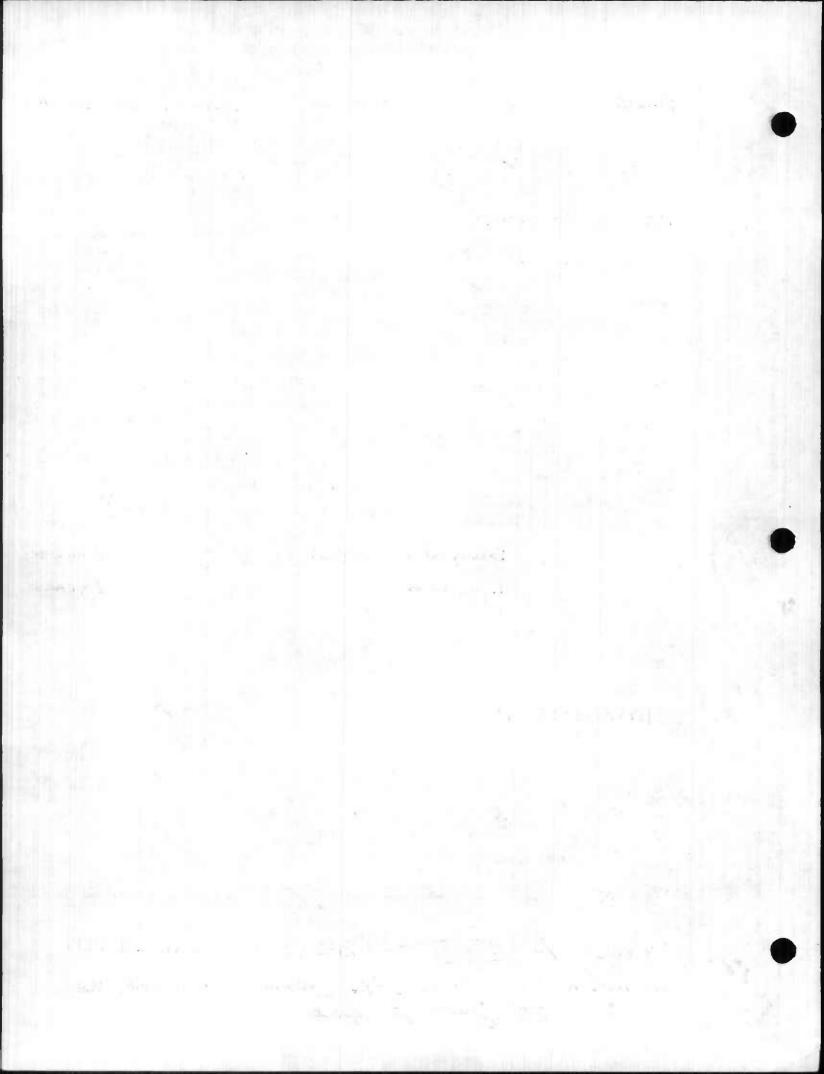
Registrar

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** GIERSCH MARIA 2:45 AM 1999 JULY 29 /Medical 4s Facility Neme (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS rthday) If Under 1 Year BAYVIEN BALLO. If Under 24 Hrs. J City AK 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplaca (State or Foreign Country) **Funeral** Months Days 1 M 20 F Hours 212-20-0387 Yrs. 6,1924 Director MD APRIL Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show BALTIMORE 1 Yes 2 110 RIVER Directo MD MIDDLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Items 23s linkson 21200 .S.A RD YT. 1403 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, 11. Merital Stetus Black, White, etc. filed within 72 hours after ☐Yes 2 No 1 ☐ Never Merried 2 ☐ Merried 8 altimore, Maryland 21215-0020 1 Yes 2 No Specify: If Yes, Give Yeer or Detes: white 3 ₩idowed 4 Divorced natural. Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) SECRETARY 1.9 U.S.F+G COAP. NIA parmit. Pages 1 and 2 should be file.
Department of Health and Mental Hy,
Important: if Item 27 is marked
any injury or 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be STOTSKY BARBARA 2 ONUFRY DASCHUK 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTO, MD AVR KoselaND 21237 BARBARA HART 907 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Duriel 2 ☐ Cremetion 3 ☐ Removel from State 17/31/99 MIDDLE RIVER 4 ☐ Donetion 5 ☐ Other (Specify) Itills Cenetery 22. Name end Address of Facility 21. Signature of Funerel Service Licensee HARTLEY Miller Funeral Home CHTD rostray Miller 7527 Harford RD BAUTO MD 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete tritervel Between Onset and Death **Physician** Bradycardic /Medical tmmedlete Ceuse (Final arrest Ominutes disease or condition resulting in deeth) **Examiner** Due to (or es e consequence of): Physician/Medical Examiner Lymphoma 2 YEARS Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or es a consequence of): physician s the burial 68760 Due to (or es e consequence of) P.O. Box Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Tes 22 No 3 Probably 4 Unknown HYPERTENSION Division of Vitai Records. þ or Attending Physician: The law requires 24b. Wera autopsy tindings available prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28c. Injury at Work? . Manner of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Affer Neture 5 Pending Investigation after death. 1 TYes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, term, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 4 ☐ Homicide • Funeral Hospital Certifying Phyalcian: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) end menner steted. Medical 29e, Certifier (Check only one) within 2 To the ŝ 29d. Dete signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number 29, 1999 RES - 000 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) HOSPITAL BALTIMORE, MD HOPKINS DM. SAI C-+A JOHNS 31. Date filed (Month, Day, Year) AUG 0 3 32. Registrer's Signeture State Registrar APP

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State of Maryland / Department of Health and Mental Hygiene 99

Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Dete of Deeth **Physician** Day A BUST 2:00 AM Jacqueline Μ. Gurski /Medical 4e. Facility Neme (If not institution, give street and number) Center 4b. City, Town, or Location of Deeth 4c. County of Deeth Baltimore Examiner 5. Social Security Number 176–16–3890 7. Age (In yrs. last birthday). If Under 1 Year If Under 24 Hrs.

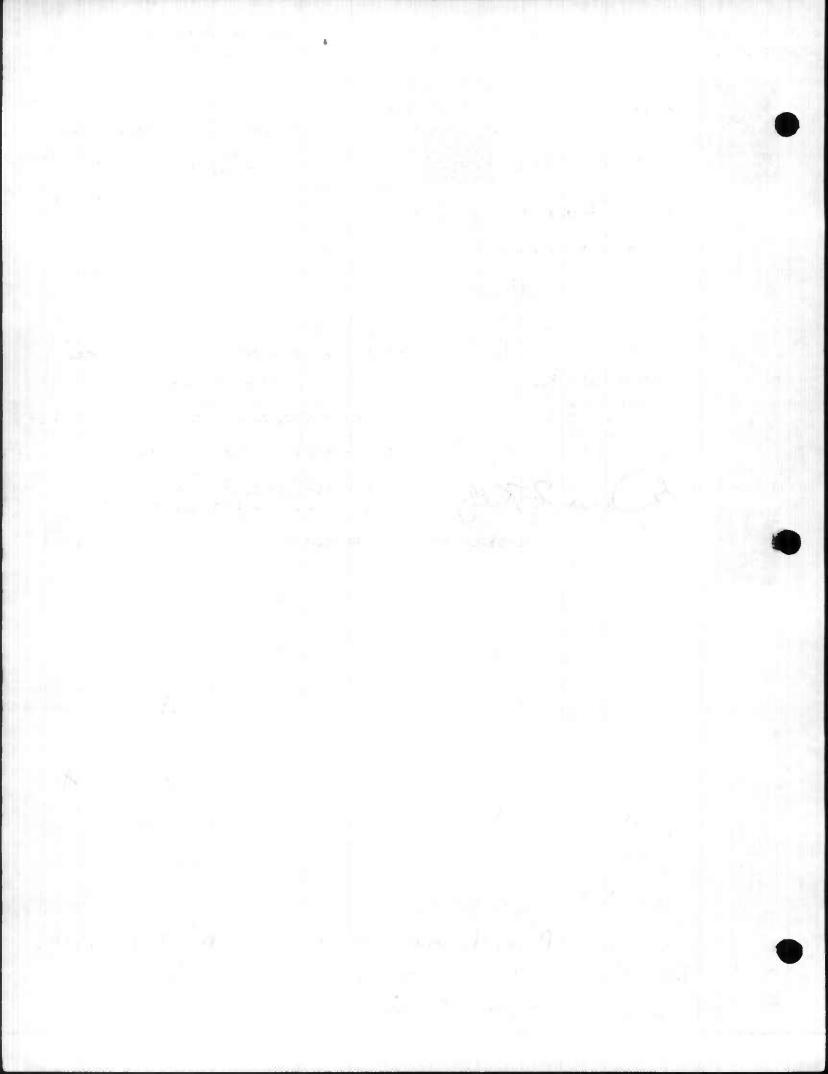
Months Deys Hours Min. 8. Date of Birth (Month, Dey, Yeer) 6-19-21 Birthplaca (Stete or Foraign Country) **Funeral** 1□ M 2\ F Director PA Usual Rasidenca of Decedent death with the Marylend 10e. Stete 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits MD Baltimore Parkville 1 ☐ Yes 2 No Director 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 8800 Walther Blvd. Apt. 1502 21234 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedant of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indien, permit. Peges 1 and 2 should be filed within 72 hours eftar or Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or ther any Injury or other traumatic event, the Medical Experience. Bleck, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☐ No If Yes, Give Yaar or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🗓 No þ Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decadent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Administrative Assistant Martin Marietta 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Frank Miller Sr. Elizabeth Brennan P 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Henry S. Gurski 8800 Walther Blvd. Apt. 1502, Baltimore, MD 21234 20b. Plece of Disposition (Neme of cametery, cremetory or other place)
Gardens of Faith 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 8-5-99 Baltimore, MD 21. Signature of Funerel Service Licenses 22. Name and Address of Facility Cvach/Rosedale Funeral Home 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, MD shock, or heart feilure. List only one cause on each line. 21237 Approximate Intervel Between Onset and Death **Physician** CEREBROVASCULAR THROMBOSIS 6 DAYS /Medical tmmediete Ceuse (Final disaese or condition resulting in death) Examiner Due to (or es e consequence of): Examiner burief-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest and Due to (or es e consequence of): physician a Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequance of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 20 No 3 Probably 4 Unknown Š 24e. Wes en eutopsy performed? Completed 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? has certificate 1 Tyes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completaly filled in by the funeral director, 25. Wes cese referred to medical exeminer? Be 26. Piece of Death (Check only one) Hospitet: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes No Medical Certification: To Inpatient 2 ER/Outpetient 3 DOA 27. Menner of Death
1 Netural
2 Accident 28b. Time of Injury 28c. injury et Work? 28d. Describa how injury occurred 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Phyelcian: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medicat Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete end place, end due to the ceuse(s) end menner stated. 29e. Certifier (Check only one) 29b. Signature and title of dertifier 29c. Licansa number 29d. Data signed (Month, Day, Year) D41410 m.0 30. Name end education and person who completed cause of deeth (Item 23a) (Type, Print)

JOGINDES . MEHTA, M. D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204 31. Dete filed (Month, Dey, Yeer) 32. Registrer's Signature State Registrar AUG 0 3 1999

- Gurski, Jacqueline



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death **Physician** URNER LYNN GOLDEN July 25 1999 18:15 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Univ. of Maryland Medical System Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Months Days Yrs. Director 217-42-9217 January 1,1947 Usual Residence of Deceden the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits ment be notified at 1 ¥ Yas 2 No Director MD Washington Hancock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Norms 23a 6125 Sensel Road 21750 USA Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, Whita, etc. e filed within 72 hours efter of hygiena. Other than "naturel", or her 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: à 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Surveyor Service permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked other any Injury or other traumatic event potes. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Roy C. Golden Anna Grace Stottlemyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angela C. Rhodes/Daughter 6125 Sensel Road Hancock, MD 21750 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State
□ Donation 5 □ Other (Specify) Warfordsburg Presbyterian 7/29/99Warfordsburg, PA 21. Signature of Funeral Service License 22. Name and Address of Facility
Grove Funeral Home, P.A. Late w. Frain St. Hancock, MD 2175 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, on each line. 141 W.Main St. Hancock, MD 21750-0368 23a. Part1. Enter the disease, or comp shock, or heart tailure. List only e Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Sepsis 24 hours disease or condition resulting in death) Examine Due to (or as a consequence of) Examiner Adult Respiratory Distress Syndrome physicien and the burial-transit be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Acute Renal Failure Box 68760 Physician/Medical Due to (or as a consequence of) multiple traumA Liver Failure 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 Yes 2 No 3 Probably 4 Unknown signed b Records, by 24b. Were autopsy tindings aveilable prior to Completed 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes X☐ No 1 Yes 2 No certificate Division of Vital Attending Physician: 8 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28d. Describe how injury occurred Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? An Hospital or Ath.

24 hours after death.

veal Director: After
in by the fur. Affer 1 Natural 5 Pending DRIVER IN MUA 1 Yes 2 No investigation UNE 28 99 6:47 pm 2Kl Accident 6 Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) /60 22 24. /6 4 Homicide To the Hospital or A within 24 hours after To the Funeral Director completely filled in b PENNSYLVANIA Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical

State Registrar 29b. Signature and title of certifier

Sharon Henry M. D. 31. Date filed (Month, Day, Year) Y. Aug. 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

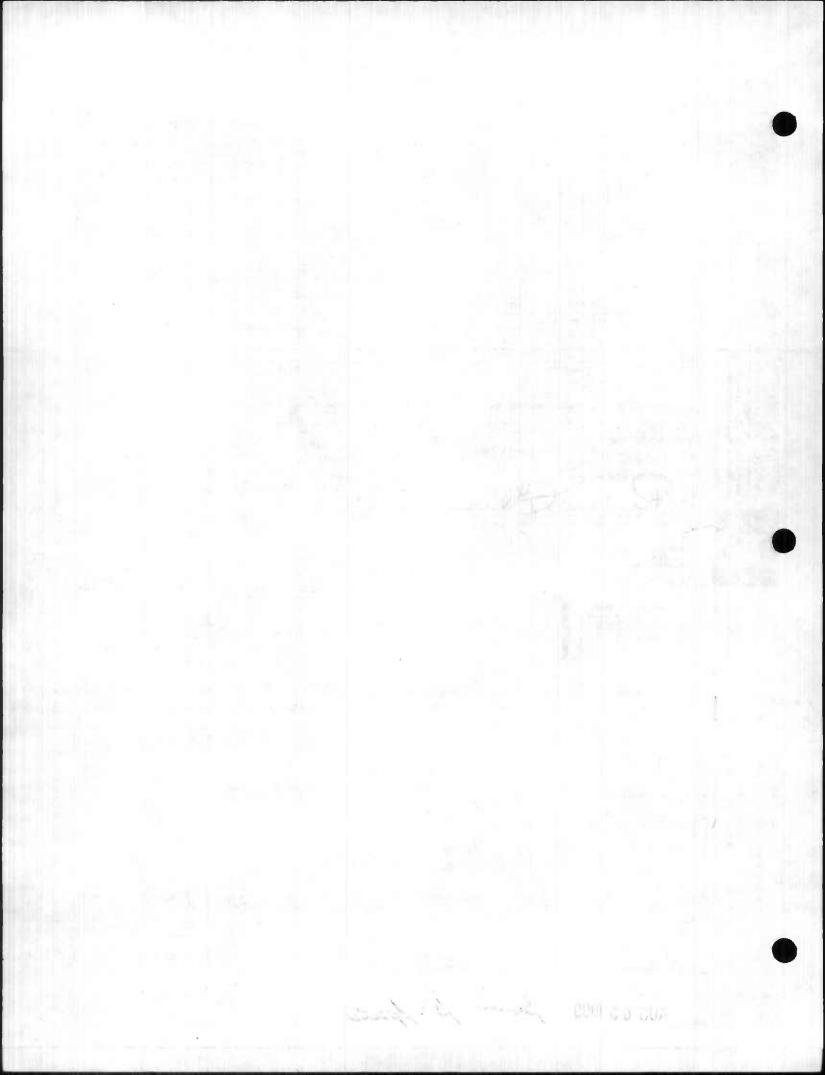
**DHMH 16 Rev 6/95** 

29c. License number

D51674

22 South Greene Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Items#18,19aperFH,#26 perPhyG774 8/3/99 EW Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Dete of Deeth Year Month 1630 Mary Elizabeth Gray 07 26 1999 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street end number) 4c. County of Deeth 13520 Route 108 Highland Howard If Under 1 Year If Under 24 Hrs. 8. Dete of Birth
Months Deys Hours Min. 12/02/1912 Birthplece (State or Foreign Country)
 OH 5. Social Security Number 7. Age (In yrs. lest birthday) 1 □ M 2 1 F Months 86 Yrs. 381-36-8646 Usual Residence of Decedent 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Fort Bend Katy 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 20006 Chasestone Court 77450 USA 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 Never Merried 2 Merried 1 ☐ Yes 2 No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade com 16e. Decedent's Usuel Occupetion 16b. Kind of Business/Industry (Giva kind of work done during most of working life. DO NOT use retired) grade completad) Elamantary/Sacondary (0-12) Collaga (1-4or 5+) Teacher Education 18. Mother's Neme (First, Middle, Maidan Sumama) Ne 11 i e 17. Father's Name (First, Middle, Last) Thomas G. Warren Wilson 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Joan Gestshman/Daughter 13520 Route 108, Highland, Md 20777 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 1 ☐ Burlei 2 ☑ Cremetion 3 ☐ Removel from Stete Balto-Wash Crematory 7/29 4 ☐ Donation 5 ☐ Other (Specify) Laurel, Md. 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Sterling Ashton Schwab Funeral Home, K. Marshall 23a. Pert1. Enter the disease, or complications that caused tha deeth. Do not enter tha mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. 21228 Interval Betwean Onset and Deeth Immediate Cause (Finel disease or condition resulting in daeth) . CARPIOMYOPA seven years ARTER HORTIC 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings aveileble prior to completion of cause of daeth? 24a. Was an autopsy periomed? 1 ☐ Yes 2 No

**Physician** /Medicai Examiner

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Box 68760,

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Physician/Medical Examiner

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Certification:

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**Physician** 

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the Maryland or 28a-f show

Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene.
Ant: If item 27 ie marked other than "naturel; or itema 23a or ury or other traumatic svent, the Medical Exercise man be a ury or other traumatic svent, the Medical Exercise man be a

Baltimore, Maryland 21215-0020

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disaase or injury that initiated events resulting in deeth) Lest

Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I.

25.	Wes case examiner		to	medical
	1 Yes			
27.	Mannar of	Death		

investigation

6 Could not be determined

5 Panding

28a. Data of Injury (Month, Day Yeer)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28b. Tima of

28c. Injury at Work? 1 Yes 2 No

Other: 4 Nursing Homa Thesidence 6 Dother (Specify/Residence 28d. Dascribe how Injury occurred

26. Plece of Death (Check only ona)

Location (Street end Number or Rurel Route Number, City or Town, Stete)

29e. Certifie (Check only one)

1 MNeturel

2 Accident

3 Suicide

4 - Homicida

Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, dete end place, end dua to tha ceusa(s) and menner as etaled.

[2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) end menner stated.

29c. License number

29b. Signature end title of certified

29d, Date signed (Month, Day, Year)

gonathan

MD ATTENDING PHYSICIAN

MARYLAND D41711

30. Neme and eddress of parson who completed causa of daath (itam 23a) (Type, Print)

JONATHAN SAFREN
31. Dete filed (Month, Day, Yeer) 3449 WILKENS AVENUE SLITE 300 BALTIMORE, MARYLAND 21229 MD

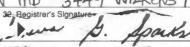
DHMH 16 Rev 6/95



Registrar

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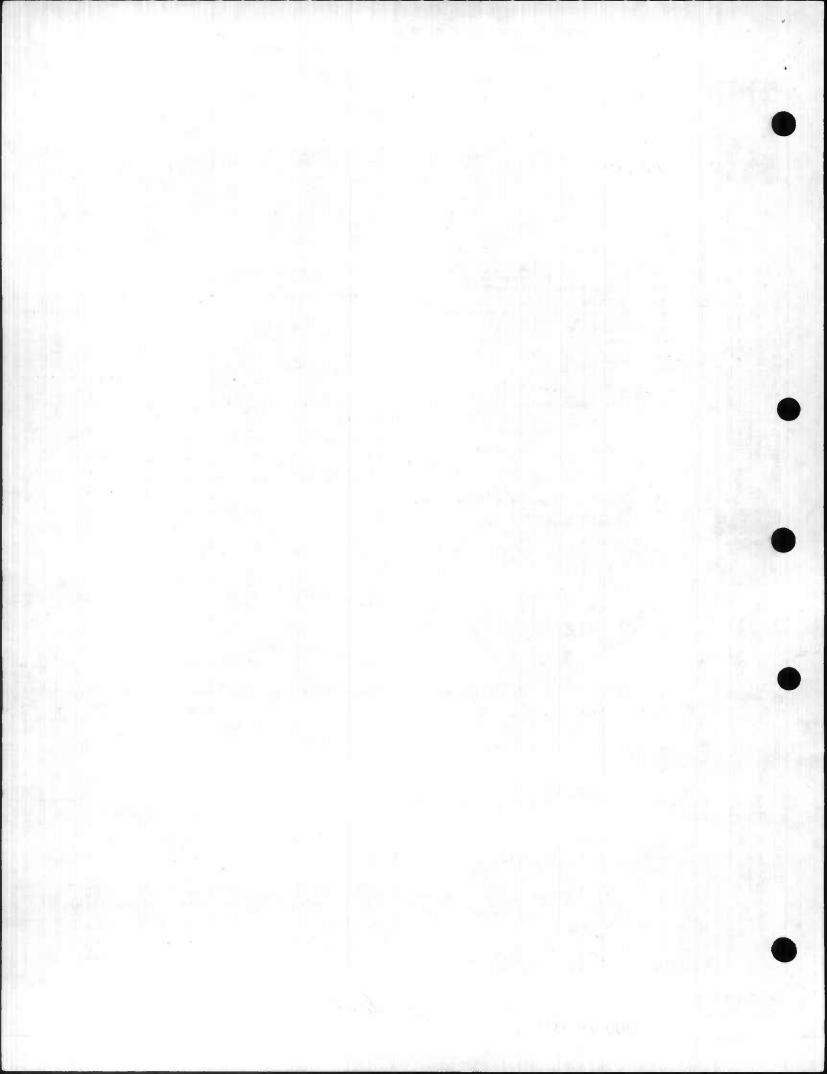
#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death GRIFFIN **Physician** BERTHA 1850 Hrs. JULY 29 1999 /Medical 4b. City, Town, or Location of Death 4c County of Death
BALTIMORE 4a Facility Name (If not institution, give street and number) Examiner NORTH WEST HOSPITAL MANDALCSTUNN 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03-18-18 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1□M 2√2 F 217-24-9522 Director MD Usual Residence of Decedent permit. Pegas 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Heelth and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23s or 28s-I show any injury or other treumatic event, the Medical Examiner must be notified at page. 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits ¥□ Yes 2□ No Baltimore Director MD 10g. Citizen of What Country? USA 10e. Street and Number 10f. Zip Code 21213 1401 N. Lakewood Avenue 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes ② No
If Yes, Give
Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 ☐ Never Merried 2 ☐ Married Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: Black by 3 DWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) in home Housewife 11th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Washington Constance Patterson Walter 19b. Mailing Address (Street and Number or Aural Route Number, City or Town, State, Zip Code) 4210 Dressage Court Randallstown, MD 21133 19a. Informant's Name/Relationship (Type, Print) Marcelene P. Kibru Baitlmore. 20b. Ptece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete pDBurial 2 ☐ Cremetion 3 ☐ Removel from State Cedar Hill Cemetery 08-04-99 Anne Arundel, CO. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) ISCHEMIC CARDIOMYOPATHY Examiner Examiner physician and s the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): 55x 68760. Physician/Medicai Due to (or es a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. PAILURE, 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 206No 1□ Yes 29 No Division of Vitai To the Hospital or Attending Physician: within 24 hours efter deeth.

To the Funeral Director: After this cartifica completely filled in by the funeral director; I 25. Was case referred to medical axaminer? 8 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 PNo Monpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 BNatural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) JULY 29, 1999 037333 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , BALTO, MD 2113] RAVIMO, NHC 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar AUG 03 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death 10 **Physician** sther /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street end number), 4c. County of Death Examiner ealth 0 0 8. Date of Birth ato ronsv mor If Undar 24 Hrs. Social Security Number 6. Sex (In yrs. last birthday) **Funeral** 1279 1 M 2 F Months Days Hours Min 12-01-Director Usual Residence of Decedent the Maryland 10a. State 10b. County Town or Location 10d. Insida City Limits 28a-f show traumetic event, the Medical Examiner must be notified at Director 1 Yes 2 □ No nor land 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? death with ò items 23a OVE Funeral 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Dacedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14 Race Amarican Indian permit. Pagas 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiena. Important: If frem 27 is marked other than "natural" any injury or other traumetic average. res 200 No Black, Whita, afc. 1 Never Married 2 Married 1 TYes T□ Yes 2 XNo If Yes, Give Year or Dates Specify þ Specify: 3 Widowed 4 □ Divorced al Completed 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) lan 10 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) amue 0 Stor 19a. Informant's Name/Relationship (Type 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 20 Naom 20b. Placa of Disposition (Name of cemetery, cremetery or other place, 20a. Method of Disposition Days 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Ramoval from State Son 4 Donation 5 Dothar (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph ome Md S .21216 North Aue W. 23a. Part1/I nfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each lina. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner physician and the burial-transit The law requires that the death certificate be executed Sequanfially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last 98 ettending p USB signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 | Yes 2 | No ò 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed page 2 has 1 ☐ Yas 2 ☐ No cartificata director. 25. Was case referred to medical axaminer?
1 ☐ Yes 2 ☐ Be 26. Place of Death (Check only one) Hospital: Certification: To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatienf 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) funaral 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Affar t 1 Waturel 5 Pending investigation n 24 hours efter death. The Funeral Director: Aftiolataly filled in by the fur 1 Yas 2 No 2 Accident 6 Could not be determined 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, streef, facfory, office building, etc. (Specify) 4 Homicide

Division of Vital Records, P.O. Box 68760, or Attending Physician: Hospital

To the Fune completely fi within 2

State Registrar

Medicai

29e. Certifier

(Check only

29b. Signature and title

31. Date filed (Month, Day, Year)

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1 Contifying Physician: To the best of my knowledge, deeth occurred et the time, dete and plece, end due to the cause(s) and manner as stated.

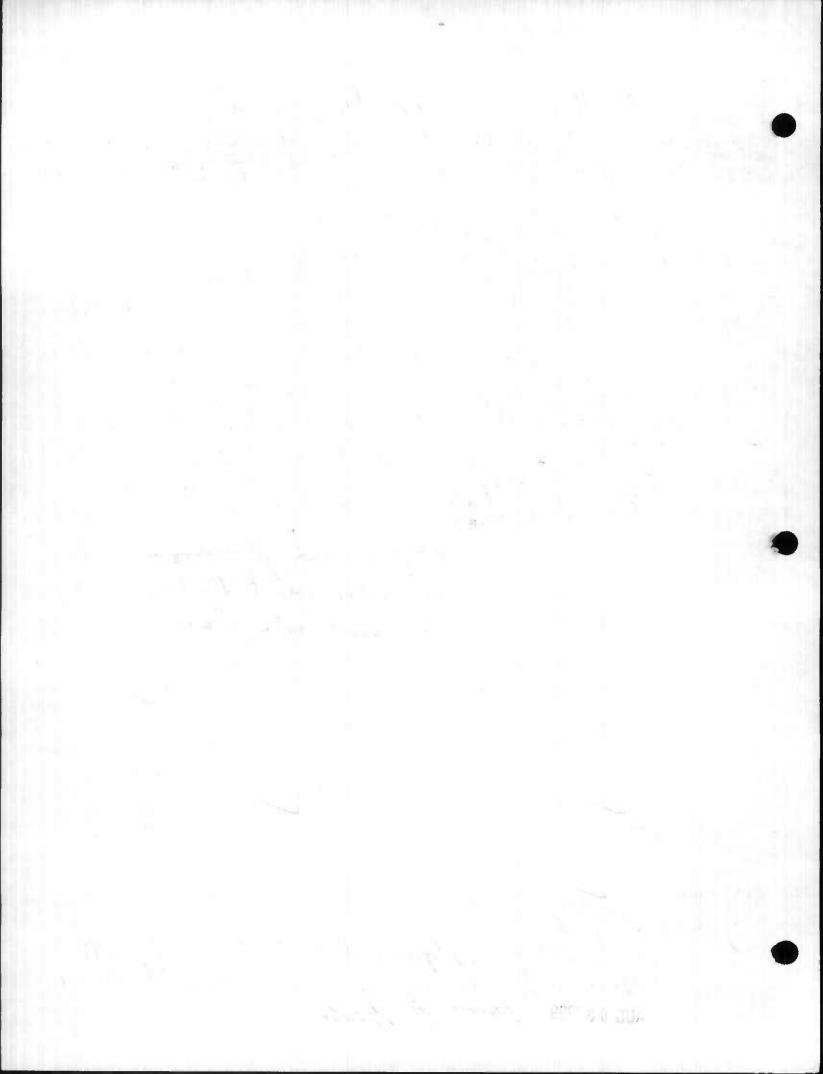
| Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29c. License number

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) rce

brane

29d. Date signed, (Month, Day, Year)



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	1. Decedent's Name (First, Middle,	Last)					2 Date of Dee	leg. No.		3. Time of Death		
Physician /Medical	EVELYN	HUDG				4. 02. 7		99 <sup>Day</sup>	Yeer	6.15 P.M		
Examiner	4e Fecility Neme (If not institution, 1'iANOR CARE R	give street and nun OLAND PAF					or Location of Deeth IMORE	4c. Count	y of Death			
uneral rector	5. Social Security Number 213 03 8435	6. Sex 1 □ M 2#□ F	7. Age (In yrs. 90	last birthdey) Yrs.	If Under 1 Ye Months De		fin. 8. Dete of Birth (Month, Dey 12/21/0	Yeer)	9. Birthp Cour	place (State or Foreign ntry)		
wow	Usual Residence of Decedent  10e. State 10b. County			, Town or Loc					JA 1			
or 28s-fs be notified Director	10e. Street and Number		B	ALTIMOF	101. Zip Cod	•		l0g. Citizen of	Whet Cour	π		
"natural, or itams 23a or 28a-1 show ad cal Examiner must be notified at eted by Funeral Director	5430 PARK HEIGH	12. Wes Dece	dent Ever in U,	S. 13. V		2 1 2 1 5  Decedent of Hispanic Origin? (Specity Yes or Nos, specify Cuban, Mexican, Puerto Ricen, etc.)  Bleck, White, etc.						
by Fun	1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed For	rces? 2√ No		Yes, specify C		uèrto Ricen, etc.)	Die	**********************************	O(C.		
Completed	15. Decedent' (Specify only highest Elementery/Secondery (0-12)	Education grade completed) College (1	-4or 5+)	16a. Deced (Give I life. D	ent's Usuel Ockind of work do OO NOT use rel	cupation ne during most of ired)	working	16b. Kind of E	Business/In	dustry		
at and 2 should be filed within 72 hours after death with the Maryland A health and Mental Hygiane. Other Z'is marked other than "natural", or items 23a or 28a-f show inter Z'is marked other than "natural", or items 23 or 28a-f show inter Z'is marked other than "natural", or items To Be Completed by Funeral Director	12 17. Fether's Neme (First, Middle, L	1		(	employe	-	Name (First, Middle,	CITY OF BALTIMORE ne (First, Middle, Meiden Sumeme)				
	THOMAS B. HILL	n (Type Print)		19h Mailin	n Address /Sir		ABETH HILL	10d. Inside City Limits   Yes 2   No				
	ROSA BARNES 1104 STODDARD CT. BALTIMORE MARYLAND 2120									1		
ry or oth	4/M Burial 2 Crametion 3 Removal from State cemetery, cremetory or other piece)								671	own, Slate		
any injury ance.	21. Signature of Funeral Service L			ES	STEP BR	dress of Fecility OTHERS F	UNERALHOME	PA.				
	23a. Pert Enter the disease, or o shock, of heart feilure. List of	complications that control one cause one	aused the deetl						21217	Approximete Interval Between		
ician dical	Immediate Ceuse (Final	/							17	Onset end Deeth		
iner 5	diseese or condition resulting in deeth)	e. 1 1 C 1	Due to (o	r es a consequ	uence of):	14010/11	PF	PRIMARY YEAR				
tal-transit	Sequentially list conditions, if eny, leeding to immediate	b	Due to (o	r es e consequ	uence of):				-			
provided as the burned edical	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest	c	Due to (or	as a consequ	uence of):				-			
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detached V Physic	Pert II. Other significant condition					0.0000000						
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director To Be	25. Wes case referred to medicel exeminer?  1 Yes 2 No	Hospitel:	npatient 2	ER/Outpatien	3□ DOA	Othor	Deeth (Check only o		ther (Speci	lfy)		
: After this e funeral di e funeral di ation: To	27. Manner of Deeth  1 Description 5 Pending 2 Accident Investign	28e. Dete (Mont	of Injury h, Dey Year)	28b. Time of Injury	28c. f	njury at Nork? Yes 2 No		now injury occurred				
To the Funeral Director: After thi completally filled in by the funeral Medical Certification: 1	3 Suicide 6 Could no determine	and 286. Place	of Injury - At hong, etc. (Specif	ome, ferm, stre	et, factory, offi	се	281. Location (5 City or Tox	Street end Nun m, Stete)	nber or Rur	ral Route Number,		
Pletaly filler edical C	29a. Certifier 1 Cartifying (Check only one) 2 Medical E	Physician: To the xaminer: On the ba	isls of examine	wledge, death tion end/or Inv	occurred et the	time, date and p y opinion, deeth o	lece, end due to the occurred et the time,	ceuse(s) end r dete and plece	nanner es s a, and due s	stated. to the cause(s)		
e de	20h Cignature and title of portifies				29c Lic	ense number		29d. Date sign	ed (Month	Dev. Year)		
To the common	230. Signature and line or certifier	garage	11				1288					

State Registrar 31. Dete filed (Month, Dey, Year)

AUG 0 3 1999

32. Registrer's Signeture

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)
RAMASWAMY J. RANGARAJAN. 7445. A

FURNACE BRANCH ROAD GLEN BURNIE, MD. 21060 Sparker



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dev Month Yeer 2:00 A.M WILLIE HARRY UVLY 1999 26 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth STELLA MARIS AT MERCY HOSPICE BALTIMORE Birthplace (State or Foreign Country) If Under 24 Hrs. Hours Min. If Under 1 Year 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) Deys ACXM 2□ F Months 247-20-3743 80 june 12, 1919 SC. Usuel Residenca of Decedent 10e Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits 1XXYes 2□ No MD. BALTIMORE 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 132 N. DENNISON STREET 21229 U.S.A. 13. Was Decadent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, 11. Maritai Status Bleck, White, etc. 1 Never Married 2 Merrled Yes 2000 1 ☐ Yes 2 ◯ No Specify: 3 ☐ Widowed 4 ☐ Divorced Yeer or Dates: BLACK 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **EMPLOYEE** BALTIMORE GAS OND ELETRI 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) NELSON HARRY FANNIE HARRY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18a. Informant's Name/Relationship (Type, Print) N DENNISON STREET BALTIMORE MARYLAND 21229 N VENNISUN
Pleca of Disposition (Neme of cemetery, cremetory or other place) MARY HARRY 20a. Method of Disposition 20c. Location - City or Town, Stete 1 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) CEDAR HILL CEMETERY 7-30-99 BALTIMORE MARYLAND 21 Signature of Funeral Service Licensee 22. Name end Address of Fecility ESTEP BROTHERS FUNERAL HOME P.A. Mycore 1300 EUTAW PLACE BALTIMORE MARYLAND 21217 Approximete Intervel Between Onset and Deeth 23a. Part1. Entof the disease, or complications that clused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, coment failure. List only one cause on each line. Immediate Cause (Final Sepsis disease or condition resulting in death) Due to (or es e consequenca of): Drabetic neuropathy Due to (or es e consequenca of) Due to (or as e consequenca of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to 24e. Wes en eutopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 No

Physician /Medical Examiner

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Pages nert of P wrt: If its ary or of

Baltimore, Maryland 21215-0020

Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in deeth) Lest

25. Wes case referred to medical exeminer? 1 ☐ Yes 2 No

26. Plece of Deeth (Check only one Stell MAYS At MERCY Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work?

27. Manner of Deeth 1 Nature 2 Accident

28e. Dete of Injury (Month, Dey Year) 5 Pending Investigation 6 Could not be determined

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

29a. Certifie (Check only one)

3 ☐ Suicide

4 Homicide

12 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner as stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred et the time, dete end pleca, and due to the cause(s) end menner stated.

29b. Signeture and title of cartifier

29d. Dete signed (Month, Dey, Year)

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) STRAIN Francis

26.6

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

State

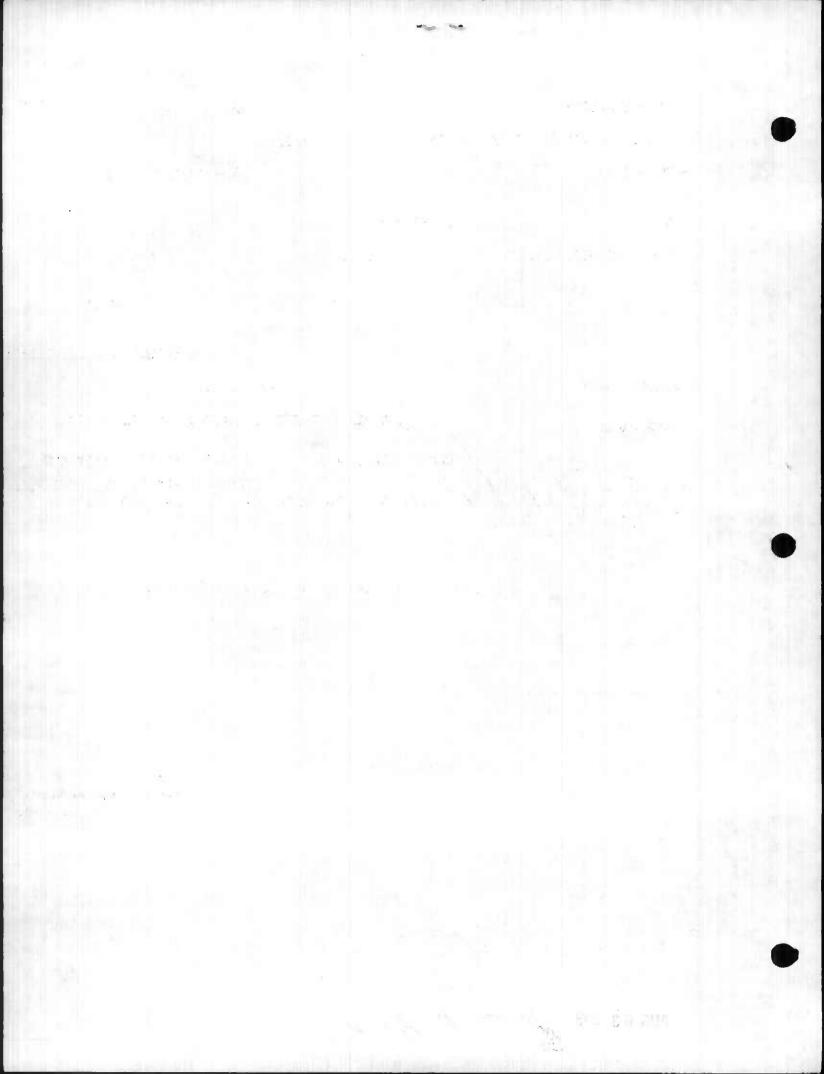
31. Dete filed (Month, Day, Yeer)

32. Registrer's Signeture

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**DHMH 16 Rev 6/95** 

Registrar



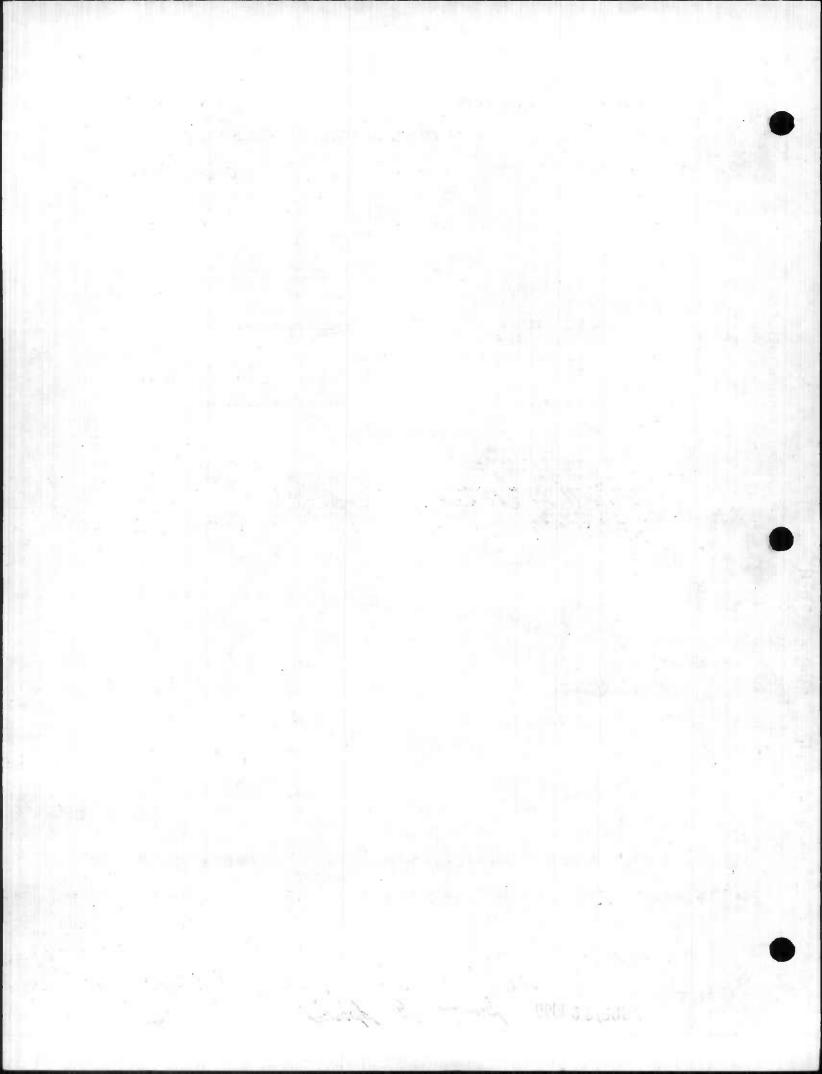
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			C	ertificate of	Death		Reg. No.	has a	6.00
	1. Decedent's Nama (First, Middla, L					2. Deta of De			3. Time of Death
Physician	EARLE	HINCKLE	=			Month	24 1	वेषेष	7:45 AM
/Medical Examiner	4a Facility Nama (If not Institution, g	ive street and number)	N	ORTH	4b. City, Town, or		h 4c. County	of Death	
X	JOSEPH RICHES	HOSPICE	828 8	JTAW STRU	T B	AUTIMOR	E		
neral	5. Sociel Security Number 6.	Sax, 7. Age	(In yrs. last birthda	y) If Under 1 Year	If Under 24 Hrs	8. Data of Bir		9. Birthplac	e (Stata or Foraign
ector	194.22.8058	100 M 20 F	70 Yrs.	Months Days	Hours Min	FEBRUAL	ay, Year)	Country	)
	Usual Rasidance of Decedant		, –			reducti	20111	7	
11	10a. Stata 10b. County		10c. City, Town or	Location		-1		10d.	Inside City Limits
Inotifiedat	Manual and		D-144						1⊠Yas 2□No
Director	Maryland  10e. Street and Number		Baltimor	10f. Zip Code			10g. Citizen of W	Deat Coverter	2
Ω Ω	305 E. 25th St	woot.		2121	0				•
mant be eral Di						7.1.1	U.S.A		
Funeral	11. Merital Status	12. Was Decedent En		<ol> <li>Was Decedent of I If Yas, specify Cub</li> </ol>	Hispanic Origin? (S san, Mexican, Puar	Specify Yes or No to Rican, atc.)	14. Rece Bleck	- American k, White, etc	
	1 Nevar Married 2 Married	If Yes, Give		1 ☐ Yas 2 ☒ No	Specify:		Specify:	Whit	e
d by	3 Widowed WDivorced	Yaar or Datas:							
- te	15. Decedant's I	Education rade completed)	16a. Dec	pedent's Usual Occur	pation	nkina	16b. Kind of Bus	sinass/Indus	itry
Completed	Elemantary/Secondary (0-12)	College (1-4or 5+	) lifa	ve kind of work done . DO NOT use retire	nd)				
00		unknown	unkr	lown			unknown		
Be	17. Fathar's Name (First, Middla, Las	it)			18. Mother's Ne	me (First, Middle	, Meiden Surname	a)	
0	unknown				unknown				
-	19a. Informant's Name/Reletionship	(Type, Print)	19b. Ma	iling Address (Stree	t and Number or R	ural Routa Numb	er, City or Town,	Stete, Zip Co	ode)
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	20a. Mathod of Disposition			position (Name of		Data	20c. Location - 0	City or Town	Stata
	1 Burial 2 Cramation 3		cematery, co	remetory or other ple	ice)	5614	200. 2002110.	J., C	, oralla
	4 Donation 5 NOther (Spec				i				
đ.	21. Signature of Funeral Service Lice	. Warden bird		22. Name and Address tate Anat		1 655 T	7 D-1-4-		A
ă	Manuel	7770 Mach		Baltimore,			. baltin	lore 5	treet
	23a. Part Enter the disease or cor	nplications that caused t	he deeth. Do not e				rrest,	A	pproximata
an	shoot or haart failura. List ont	y ona causa on aach iina						O	terval Between nset and Death
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o o	that initiated evants rasulting in death) Last	D	ue to (or as a cons	equence of):					
Me Me	,								
200		d							
Physician/	Part II. Other aignificant conditions	contributing to death but	not rasulting in tha	underlying ceusa gi	ven in Part I.	23b. Did	tobacco use con	tributa to th	ne cause of death?
th.						1□	Yaa 2 No	3 Probet	oly 4 🗆 Unknown
by P								7	
2						24a. Was	an autopsy	24b. Ware	autopsy tindings
ete						perfe	ormed?	comp	able prior to eletion of cause
Completed								of dea	ath?
S						10	Yas 2 No	1 🗆 Y	as 2 No
Be	25. Was casa refarred to medical examinar?				26. Placa of De	ath (Check only	ona)		
2	1 Yas No	Hospitel: 1 Inpatient	2 ER/Outpat	ient 3 DOA	her: 4 Nursing I	Homa 5 Rasi	idence 6 Othe	r (Specify)	HOSPICE
	27. Mangar of Death	28a. Data of Injury (Month, Day	28b. Time		ry at	28d. Describe	how injury occurre	ed	
Certification:	1 Natural 5 Panding 2 Accident invastigetic		Year) Injun		Yes 2 No				
5	3 ☐ Sulcide 8 ☐ Could not	A Zea. Place of injur	y - At homa, farm,	street, fectory, office	K.	28f. Location	Street and Number	er or Rural R	Routa Number,
F	4 Homicida	building, etc.	(Specify)			City or To	wn, State)		
	29a, Certifying P	hysician: To the best of	my knowledge de	ath accurred at the f	me date and also	e and due to the	cousple) and man	nner ee etet	ad
edicai		miner: On the basis of e	xaminetion and/or	invastigation, in my	opinion, death occ	urred et tha tima,	data end place, a	ind dua to th	e cause(s)
Med		and mannar state	90.	one the	en number	1	20d Data size of	(Month C	Vene!
	29b. Signature and title of outsitier	0/		29c. Licen	se number	7	29d. Date signed	(MOHIN, Da	y, 1001)
	NAV	WF	~	D	2636	1	July	24,	1999
	30. Name and address of person who	completed causa of dea	th (Item 23a) (Typ	e, Print)			1	1	
	Daugust	Roce	ND C	114/	MIDGIR	= ()	7 DME.	A A	1D2100
State	31. Data filed (Month, Day, Year)	32. Registrar	s Signatura 4		AND IT	-100	CUT-112/	7/	- CVTC
gistrar	AUG 0 3 19	99 Bene	ve &	Ann a	41				
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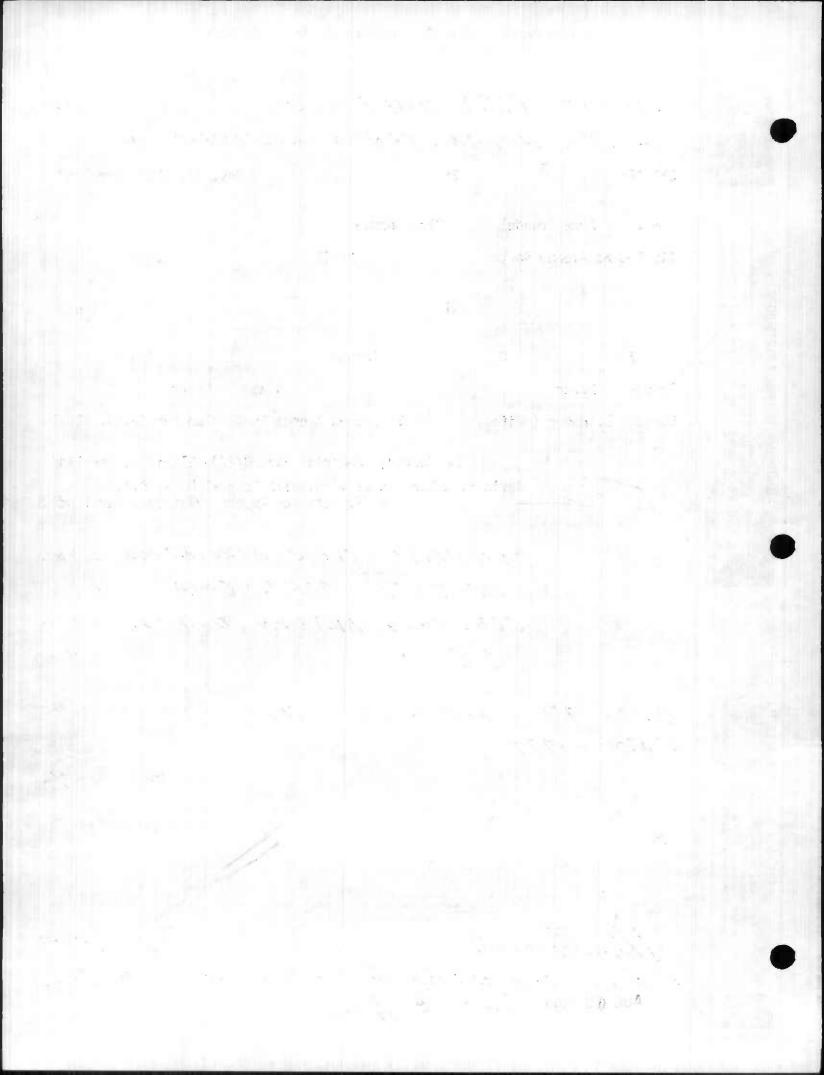
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State of Maryland / Department of Health and Mental Hygiene ()

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) HUBER, JULY **Physician** JOSEPH EARL 11:30 /Medical 4e Facility Name (If not Institution, give street and number) Examiner HOSPITAL CENTER If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex ₩ M 2 F Birthplace (State or Foreign Country) **Funeral** Months Days 216-18-0866 Nov. 24, 1923 Maryland Director Usuel Residence of Decedent the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23s or 28s-f show traumstic event, the Medical Examinar must be notified at 1 ☐ Yes 2 💢 No Directo Anne Arundel Glen Burnie Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours aftar death with t Department of Haelih and Mental Hygiena. Important: If Item 27 is marked other than "naturel", or items 23a or 's any Injury or other traumetic event, the Medical Examiner must be no 110 Second Avenue South U.S.A. 21061 Funeral 12. Was Decedent Ever In U,S.
Armed Forces?

1 Tyes 2 No
If Yes, Give
Year or Dates: WWII Was Decedent of Hispenic Orlgin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Merried 3altimore, Maryland 21215-0020 1 ☐ Yes 2√☐ No Specify g 3 □ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 7th Lineman BGE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George Huber Agnes Lamarr 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Loretta B. Huber (Wife) 110 Second Avenue South Glen Burnie, Md. 21061 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Meadowridge Memorial Park 8/2/99 Elkridge, Maryland . Signature of Funeral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. Kevin E. Ecker 237 E. Patapsco Avenue Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onsel and Deeth Physician /Medical fmmediate Cause (Final disease or condition resulting in death) METASTATIC COLON CARCINOMA Examiner Examiner CARCINOMA end I-transit tha death cartificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last physician er s the buriel-t Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 5425 Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ESOPHAGEAL ULCERS 24b. Were autopsy findings available prior to completion of cause of death? CABG-1997 24a. Was an autopsy performed? 2 X No Hospital or Attending Physician: 25. Was case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No funaral 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Neturel
2 Accident 5 Pending investigation aftar death. Director: Aft 1 ☐ Yes 2 ☐ No n 24 hours after dea ve Funeral Director pletely filled in by th 3 Suicide 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 | Homicide Certifying Phyeician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and menner es steted.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and placa, and due to the cause(s) and menner stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D28988 quellano III 3001 South Hanever St. Balt. MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARQUILLAMOMO 32. Registrar's Signature Registrar



### Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible.

ion	#5 PER F.H. G774 8-13-99 WR. Certificate of Death		Reg. No.	10.71
ian cal	1. Decedent's Name (First, Middle, Last)  VERNA  HAW (OCK	2. Data of De Month	30 1999	3. Time of Death
ner	HAR BOR HOSPITAL CEVTER BAL  5. Spelling Seguring Symptoer  6. Sax  1 M 2 X F  86 Yrs. Months Days Hours I	Hrs. 8. Deta of Bir Month, Da Feb. 7	th 9. Birt	inhplece (Stata or Foreign unitry)
	Usual Residence of Dacedant  10a. State 10b. County 10c. City, Town or Location			10d. Insida City Limits
to	Md. N/A Baltimore			1X Yas 2 No
Funeral Director	10e. Street and Number 10f. Zip Coda		10g. Citizen of Whet Co	ountry?
rai	3807 Brooklyn Avenue 21225		U.S.A.	
by rune	11. Merital Status  12. Was Dacedant Ever In U,S. Armed Forcas?  1 □ Navar Married 2 □ Married  3 □ Widowed 4 □ Divorced  12. Was Dacedant of Hispanic Origin If Yas, specify Cuban, Mexican, P  11. Yas 2 □ No  12. Was Dacedant of Hispanic Origin  13. Was Dacedant of Hispanic Origin  14. Yas, specify Cuban, Mexican, P  15. Was Dacedant of Hispanic Origin  16. Yas, Specify Cuban, Mexican, P  17. Yas 2 □ No  18. Yas Dacedant of Hispanic Origin  19. Was Dacedant of Hispanic Origin  11. Yas, specify Cuban, Mexican, P  11. Yas, Specify Cuban, Mexican, P  12. Was Dacedant of Hispanic Origin  13. Was Dacedant of Hispanic Origin  14. Yas, specify Cuban, Mexican, P  15. Yas, Specify Cuban, Mexican, P  16. Yas, Giva  17. Yas 2 □ No  18. Yas Dacedant of Hispanic Origin  19. Yas, specify Cuban, Mexican, P  10. Yas, Sivant  11. Yas, Specify Cuban, Mexican, P  10. Yas, Sivant  11. Yas, Specify Cuban, Mexican, P  16. Yas, Giva  17. Yas, Specify Cuban, Mexican, P  18. Yas, Specify Cuban, Mexican, P  19. Yas, Sivant  19. Yas, Specify Cuban, Mexican, P  10. Yas, Sivant  10. Yas, Specify Cuban, Mexican, P  10. Yas, Sivant  11. Yas, Specify Cuban, Mexican, P  10. Yas, Sivant  11. Yas, Specify Cuban, Mexican, P  11. Yas, Specify Cuban, Mexican, P  12. Yas, Specify Cuban, Mexican, P  13. Was Dacedant of Hispanic Origin  14. Yas, Specify Cuban, Mexican, P  15. Yas, Specify Cuban, Mexican, P  16. Yas, Sivant  17. Yas, Specify Cuban, Mexican, P  18. Yas, Specify Cuban, Mexican, P  18. Yas, Specify Cuban, Mexican, P  19. Yas, Specify Cuban, Mexican, P  19. Yas, Specify Cuban, Mexican, P  19. Yas, Specify Cuban, Mexican, P  10. Yas, Specify Cuban, Mexican, P  10. Yas, Specify Cuban, Mexican, P  10. Yas, Specify Cuban, Mexican, P  10. Yas, Specify Cuban, Mexican, P  10. Yas, Specify Cuban, Mexican, P  10. Yas, Specify Cuban, Mexican, P  10. Yas, Specify Cuban, Mexican, P  10. Yas, Specify Cuban, Mexican, P  10. Yas, Specify Cuban, Mexican, P  10. Yas, Specify Cuban, Mexican, P  10. Yas, Specify Cuban, Mexican, P  10. Yas, Specify Cuban, Me	i? (Specify Yes or No Puarto Rican, atc.)	Black, White	
Completed	15. Decedant's Education (Spacify only highest grada complated)  Elamantary/Secondary (0-12) 12th  15. Decedant's Usual Occupation (Give kind of work done during most of life. DO NOT use ratired)  Retail		16b. Kind of Business/	Industry
BeC		Nema (First, Middle,		on company
2	Samuel Lane Cat	cherine S	napp	
	196. Informent's Neme/Reletionship (Type, Print)  Herbert R. Hancock (Husband)  19b. Mailing Addrass (Street and Number of 3807 Brooklyn Avenu			
-	Herbert R. Hancock (Husband) 3807 Brooklyn Avenu	Data	20c. Location - City or	
	1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramovai from State cematary, cramatory or other place)			
+	4 □Donation 5 □Other (Specify) Cedar Hill Cemetery  21. Signature of Funeral Survice Licensee McCully-Polyniak	8/2/99	Baltimore,	marylanu
	237 E. Patapsco A  23a. Parl1. Enter the disease, or complications that carsed the death. Do not enter the mode of dying, such as carsed the death. Do not enter the death. Do not enter the death. Do not enter the death. Do not enter the death. Do not enter the death. Do not enter the death. Do not enter the death. Do not enter the death. Do not enter the death. Do not enter the death. Do not enter the death. Do not enter the death. Do not enter the death. Do not enter the dea	rdiec or respiratory a	rrast,	Approximete thiarval Between Onsat and Death
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an/Medical Examiner	Dua to (or as a consequence of):	COHT F	-00T	1 MONTH
edicai	Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disaase of Injury that initiated awants			MONTH  to the cause of death?
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Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month Year **Physician** BEULAH E HARDINGHAM 1999 340 AM August /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Roceda/e

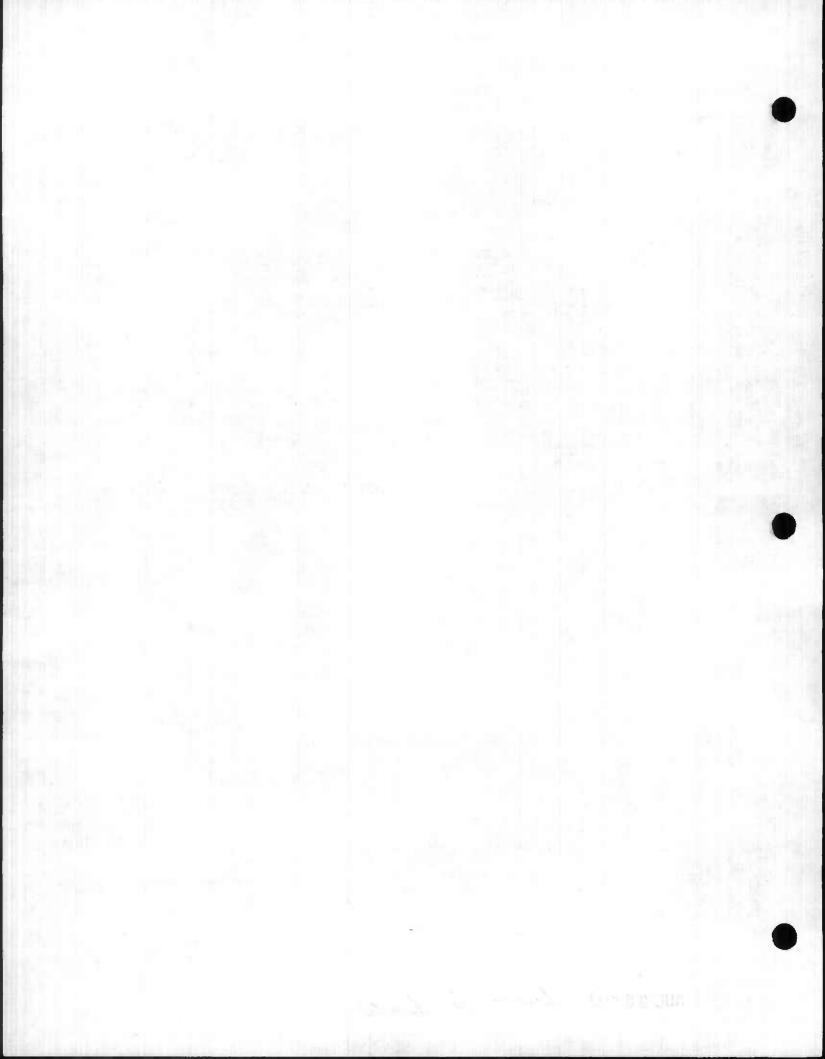
If Undar 24 Hrs. 8. Data of Birth
Hours | Min. (Month, Day, Year) Square Center Hospital tranklin If Under 1 Yaar 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 212-30-4043 1 M 2 KF Yrs. 87 Jan.1, **Director** Virginia Usual Rasidence of Dacedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Director Md. Baltimore 1 ☐ Yas 2 ☐ No Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 414 South MArlyn Ave. Nerna 23a 21221 TISA Funeral 12. Was Decedant Evar in U,S. Armed Forcas?

1 Yas 2 No Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indien, Black, Whita, atc. 11. Marital Status 1 ☐ Nevar Married 2 ☑ Married 'natural', or 1 Yas 3€ No Specify: Specify: White à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry filed within Hygiene. Wher then Elamentary/Secondary (0-12) Collega (1-4or 5+) Waitress Resturant 8th 17. Father's Nama (First, Middla, Last) 18. Mothar's Nema (First, Middle, Meiden Sumama) Be 2 should be 1 and Mental 9 is marked William Strange Minnie Caraco To 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Department of Health a Important: If New 27 is any injury or other trace Pages 1 and 2 William HArdingham/husband 414 South NArlyn Ave. Baltimore Md. 21221 altimore, 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Garrison Forest Cemetery 8/4/99 4 ☐ Donation 5 ☐ Othar (Specify) Owings MI11s 21. Signature of Funaral Sarvice Licensee 22. Nama and Addrass of Facility Connelly Funeral Home of Essex 300 MAce AVe. Baltimore Md. 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Batween Onset and Deeth **Physician** /Medical Immediata Causa (Final Urosepsis disaasa or condition resulting in death) Examiner Dua to (or es a consequence of): Examiner certificata be axecuted physician and Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disease or Injury that initiated events rasulting in death) Last Dua to (or as a consequence of): Physician/Medical Dua to (or as a consequance of): for usa as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Nunknown signed I by 24b. Ware autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed 1 Yas 2 No 1 Yes 2 No certificate Attanding Physician: 25. Was case retarred to medical Be 26. Placa of Deeth (Check only ona) Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yas 2 No Certification: To 1 Inpetiant 2 □ ER/Outpetient 3 □ DOA this funeral 28a. Dete of Injury (Month, Dey Year) 27. Mannar of Death 28c. tnjury at Work? 28d. Describe how injury occurred 28b. Tima of ospital or Attan.

44 hours efter death.

4 Funeral Director: After and a property of the formal of the formal property. After 1 Natural 5 Panding 1 ☐ Yas 2 ☐ No invastigetion 2 Accidant 6 Could not be datarmined 3 Suiclda 281. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida in 24 hour. 1 Certifying Physician: To the best of my knowledga, death occurred at the time, date end place, end due to the ceuse(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, deta end place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature and titla of certifian 29c. License number 29d. Data signed (Month, Day, Year) 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) 21237 Savitha 9000 Franklin Drive Shivananda MD 31. Date filed (Month, Day, Year) 32. Registrar's Signetura State AUG 0 3 1999 Registrar party **DHMH 16 Rev 6/95** 

**ORIGINAL** 



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month July 31, 1999 4:50 PM Harden 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not Institution, give street end number) 4c. County of Deeth Brightwood Center Brooklandville Baltimore If Under 1 Year If Under 24 Hrs. 8. Dete of Birth
Hours Min. (Month, Dey, Yeer) 7. Age (In yrs. lest birthdey) Birthpleca (State or Foreign Country) 1□M 20 F Months 89 Yrs. May 9, 1910 Baltimore, MD 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore Freeland 10f. Zip Code 10g. Citizen of What Country? 2520 Beckleysville Road 21053 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ঐ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Herold Sophie Hvalak 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Mary M. Iampieri/Daughter 2520 Beckleysville Road Freeland, MD 21053 20b. Plece of Disposition (Neme of cematery, crematory or other plece Most Holy Redeemer 20c. Location - City or Town, Stete Dete 1 Burial 2 □ Cremetion 3 □ Removal from State Aug. 4, 4 Donation 5 Other (Specify). Cemetery 1999 Baltimore, MD 22. Name end Address of Fecility
Jemmon Funeral Home of Dulaney Valley, 10 W. Padonia Road Timonium, MD 21093 sease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, ure. List only one cause on each line. Intervel Between Onset and Deeth 15 MINS Due to (or es e consequence of): Concestive vears Due to (or es e consequence of): Dron As years Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? CHRONIC Renal Failure 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings avelleble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Wes case referred to medical examiner? 28. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner as stated.
2 Medical Examiner: On the basis of examinetion end/or Investigetion, in my opinion, death occurred et the time, dete end plece, and due to the cause(s) end menner steted. 29b. Signature and title of contiller 29c. License number 29d. Dete signed (Month, Dey, Year) Medical AHENDING

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Heelin and Mental Hygiene.

Theoricant: If Itam 27 is marked other than "naturel; or items 23a or any injury or other traumatic event, ire Medical Estation mental or

Physician /Medical

Examiner

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page 2

After this uneral

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Certification:

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Baltimore, Maryland 21215-0020

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5. Sociel Security Number

Usuel Residence of Decedent

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20e. Method of Disposition

immediate Cause nel disease or condition resulting in death)

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest

1 ☐ Yes 2 No

27. Menner of Deeth

1 Neturel

3 Suicide

29e. Certifier

2 ☐ Accident

4 Homicide

(Check only one)

21. Stanger

214-05-3605

10e. Street and Number

10e. Stete

The law requires that the death certificete be executed Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician:

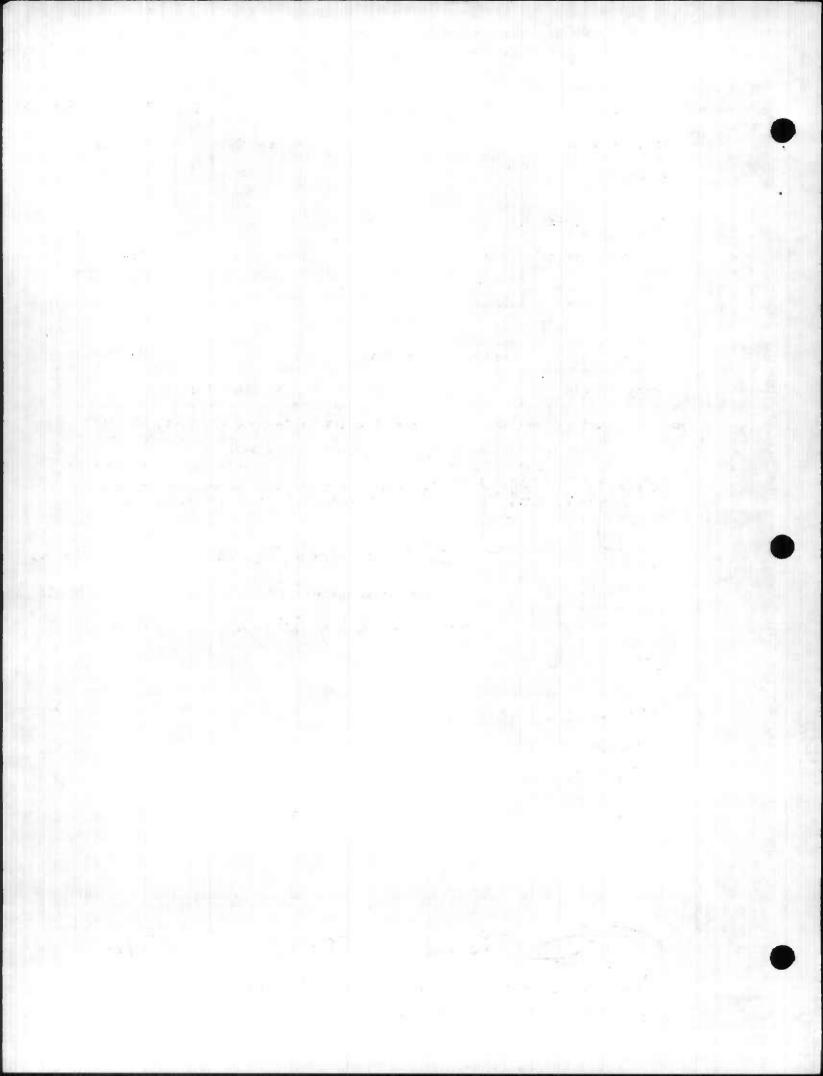
Registrar

31. Dete filed (Month, Dey, Year) AUG 0 3 1999

- ChWARTZ MA

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

115 E. MelRaje 32. Registrer's Signature



WRC 99-4429-510 Please Type or Print in Black indelible ink. Assure All Copies Are Legible. ALBERT State of Maryland / Department of Health and Mental Hygiene HOWARD AMEND ITEMS: #23 PART I, 27, 28A-F PER MEO G774 8-11-99 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Albert Leon Howard IV 27, 1999 JULY 7:10 PM. /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SINAI HOSPITAL BALTIMORE If Under 1 Year 5. Sociel Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplece (Stata or Foreign Country) **Funeral** Days Months Hours 1 M 2 F 217-90-6735 31 Director Md Usual Residence of Decedent the Maryland 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Vas 2 No Md Funeral Directo N/A Baltimore 28a-f 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? r, or flarm 23a or 2 xaminer must be n 2922 Rosalind Avenue USA 21215 14. Raca - American Indien, Black, Whita, atc. 11 Maritel Status 12. Wes Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Pages 1 and 2 aboutd be filed within 72 hours after ment of Health and Mental Hyglene.

ett. if them 37 is reniced other than "naturel", or the law or of the trained owent, the Medical Examinatiny or other trained owent, the Medical Examinative. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) N/A (1-4or 5+) Various Jobs Laborer 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert Leon Howard, III Maxine Sampson 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maxine Sampson Green- Mother 2922 Rosalind Avenue Baltimore, Md 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 Cramation 3 Removel from Steta
4 Donetion 5 Other (Specify) Metro Crematory 8-2-99 Catonsville, Md 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility March F/H West 4300 Wabash Avenue Baltimore, Md 21215 **Physician** /Medical Examiner or Attending Physician: The law requires that the death certificate be executed pue Division of Vital Records, P.O. Box 68760,

23a. Pert1. Enter the disease, or comp shock, or hearf eilure. List only of the disease or condition.	licetions that caused the dea ne cause on each line.				ac or respiretory	errest,	Approximete Intervel Between Onset end Death
resulting in deeth)	a	or es a consequ					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	bDue to (	or es e consequ	ence of	:			
Cause (Diseese or Injury that initiated events resulting in death) Last	Due to (	or es a consequ	enca of)	:			
Pert II. Other significant conditions con	ntributing to death but not re	sulting In the und	derlying	cause given in Pert I.			ontribute to the cause of death?
11/1/1				n, - 1	per	es en eutopsy formed?	24b. Wara autopsy findings available prior to completion of cause of death?
25. Wes case referred to medical				00 Div 4 D		Yes 2□No	1 Yes 2 No
examiner?	Hospitel: 1 ☐ inpatient 2 5	ER/Outpatient	3□ D	Other	eth <i>(Check onl</i> )	sidence 6 🗆 Ott	ner (Specify)
27. Menner of Death  1 Netural 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Day Year) 7-27-99	28b. Time of Injury 6:36		28c. Injury et Work? 1 ☐ Yes 2 ☑ No		how injury occur	
3 ☐ Sulcide 6 ☐ Could not be determined	28e. Plece of Injury - At h building, etc. (Speci HOME	nome, ferm, stre	et, fecto	y, office		(Street and Num own, State) 292 (RE, MARYL	PEZ ROSAL IND NAVE".
29e. Certifier (Check only one)  1 Certifying Physical Exami	sicien: To the best of my knoner: On the besis of examine and menner steted.	owledge, deeth e etion end/or inve	occurred	l et the time, date end plac n, in my opinion, deeth occ	e, end due to the curred at the time	e cause(s) and m e, date and placa,	enner as stated. snd due to the cause(s)
29b. Signature and title of certifier	Sh 00	044	29	O.C.M.E.		29d. Data signe	ed (Month, Day, Year)

**DHMH 16 Rev 6/95** 

State

Registrar

To the Hospital or Attendi within 24 hours after death To the Funeral Director: A

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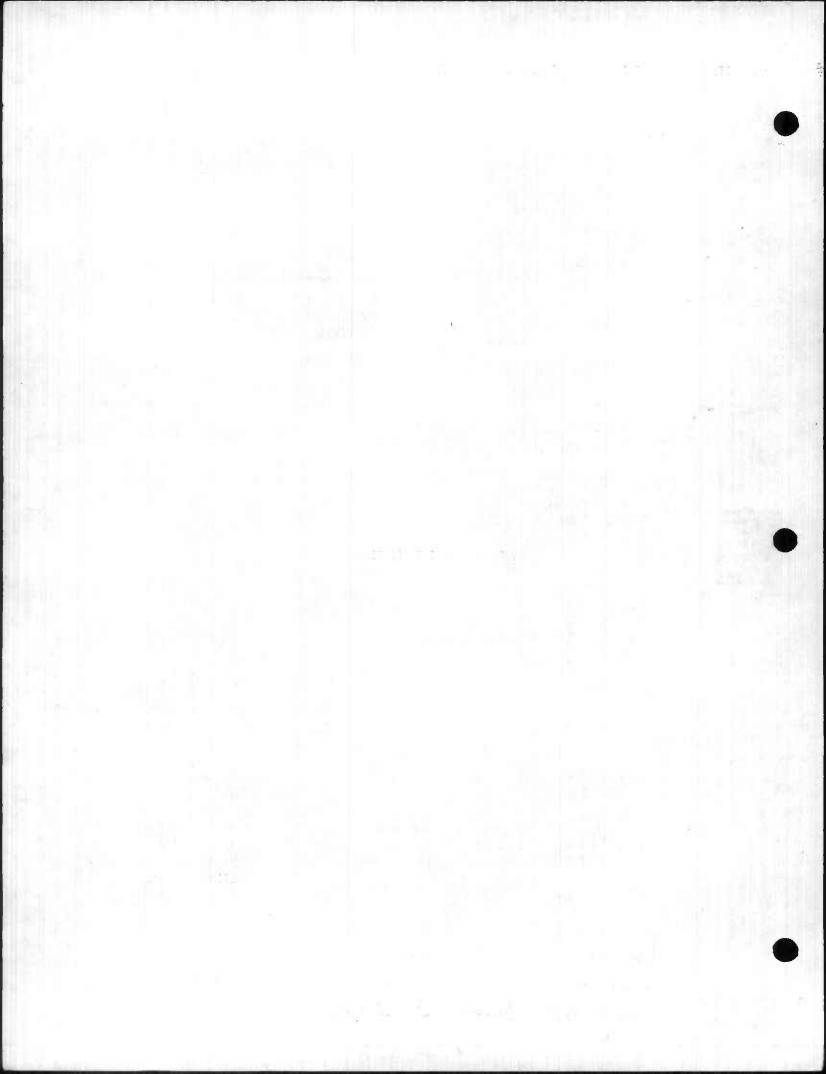
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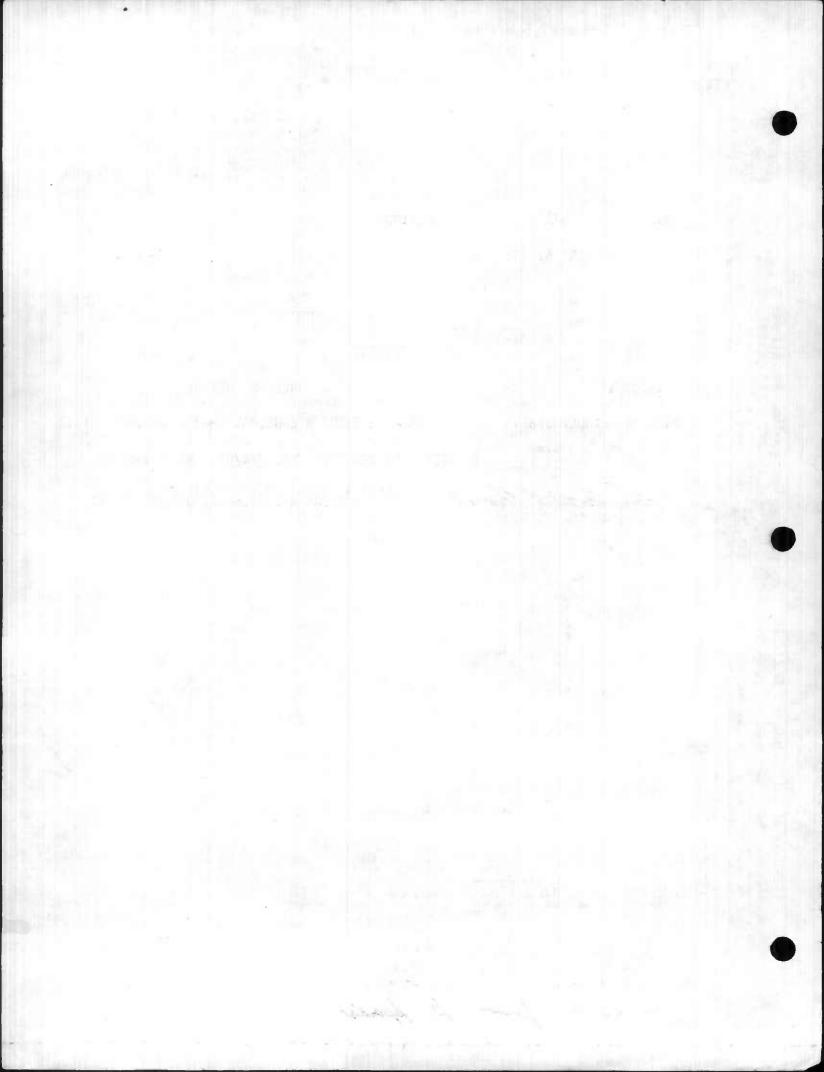
111 Penn Street, Baltimore, Maryland 21201

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eted cause of death (Item 23a) (Type, Print)

32 Registrar's Signeture





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Date of Death 3. Time of Death  $J_{uly}^{Month}$  30,  $^{Day}_{uly}$  399 3:20pm John Joseph Imwold, Sr. 4e. Fecility Neme (tf not institution, giva street end number) 4b. City, Town, or Location of Deeth 4c. County of Daath Baltimore Gilchrist Center Towson If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) if Undar 1 Year 8. Dets of Birth (Month, Day Year) 0Ct. 11,1923 9. Birthpiace (State or Foreign Deys 1**X** M 2□ F Months Hours Min 75 Maryland 218-12-2890 Usual Residence of Decadent 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 XNo Perry Hall Maryland Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21236 **United States** 9326 Pent Angel Way Was Decedent Ever in U,S. Armed Forces?

1 X Yes 2 □ No If Yes, Give Yeer or Dates: WWI Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritat Stetus 14. Race - American Indisn. Bteck, White, etc. 1 Never Married 2 Married WWII 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorcad 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Wholesale Drug Representative Pharmaceutical 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Meiden Surname) Katherine M. Yehle Harry E. Imwold, Sr. 19e. tnforment's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 9326 Pent Angel Way Perry Hall, MD 21236 Mrs. Mildred Imwold / Wife 20b. Piaca of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriei 2 Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 8/2/99 Towson, Maryland 21. Signeture of Funer Lecnard J. Ruck, Inc. Funeral Home Servica Licensee Timothy Harman Man 5305 Harford Road Baltimore, MD 21214 23a. Part 1. Enter the diagree, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heer fail to List only one cause on each line. Approximete Intervel Between Onsat and Death immediate Ceuse (Finei concer 2 month PANCREATIC disease or condition resulting in death) Due to (or as a consequence of): Due to (or as e consequença of): Due to (or es a consequence of) 23b. Did tobacco usa contributa to the cause of death? 1 Yes A No 3 Probably 4 Unknown 24b. Were eutopsy findings availebia prior to 24e. Was an eutopsy performed? completion of cause of death? 1 ☐ Yes 2 XNo 1 ☐ Yes 2 ☐ No 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Nother (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

Physician /Medicai Examiner

Physician

/Medical

Examiner

**Funeral** 

Director

rel', or items 23a or 28a-f show Examiner must be notified at

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natural

and Mental Hygie

should be

Pages 1 and 2 st ment of Health and Int: If item 27 is n

permit. Page Department of Important: If any injury or

The Medical ified within 72 h Hygiene. other than "natu

Director

Funeral

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Completed

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death

Baltimore, Maryland 21215-0020

Box 68760.

P.0.

Records,

Division of Vital

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and 2 for u signed by the ate has b certificate Hospital or Attanding Physician: 24 hours after death.

Funeral Director: After this certifical in by the Funeral Di the Funeral Di To the Within 2 To the

Examiner Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Last Physician/Medical Part tl. Other eignificent conditione contributing to death but not resulting in the undariying cause given in Part i. by Completed 25. Was case referred to medical Be To 1 Yes 2 No 28e. Date of tnjury (Month, Dey Year) Certification: 27. Mennar of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury Neturet 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Coutd not be determined 3 Suicide 28f. Location (Street and Number or Rurat Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide TSCertifying Physician: To the best of my knowledge, deeth occurred at the time, date and piace, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piaca, and due to the cause(s) Medical 29a. Certifier end manner stated 29b. Signeture and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year)

State Registrar W-A-Riley

AUG 0 3 1999

31. Dete filed (Month, Dey, Year)

GBMC 32. Registrar's Signature

30. Name end eddress of person who completed cause of death (item 23a) (Type, Print) 6701 N. Charles St. Balto. md 2,1204

1)25205

Jdy 30,1899

DHMH 16 Bay 6/95

The profession of the same the set it is not the property and the same of the set The state of the s

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Deeth B. JONES Physician CLLF TON 5:00 AM. /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Walprook Baltimore NA Avenue If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Dey, Year) 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year 6. Sex Birthplaca (State or Foreign Country) **Funeral** Days 100 M 20 F 66 Yrs. Months 238-48-7896 Director 1933 40-Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Show 1 Yes 2 □ No NA Saltimore Funeral Director 284-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 21216 Malbrok Huenne U.S.A 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Meritel Stetus Pages 1 and 2 should be filed within 72 hours after on nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or ite 1 ☐ Never Merried 2 ☐ Merried 21215-0020 1 ☐ Yes 2 No Completed by Specify Specify: Black 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. PO NOT use retired) 16b. Kind of Business/Industry UNIL Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) aborer 1 th grade Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Sarah 9 Jones Daniels ar 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/2/6 Balto, reg Brother 2140 Smallwood 10nesaltimore, 20b. Place of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, State Department of H Important: If its any injury or of once. 1 Burial 2 Cremetion 3 Removel from Stete
4 Donetion 5 Other (Specify) Crematory atonsuilla, Ma 10 21. Signeture of Funeral Service Licensee 22. Name end Address of Pacility 1300 Wat 21215 la Leverue 2 ans W Wabash 40, Mac 23e. Pert1. Enter the disease, of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Final INFARCTION MYOCARDIAL ONE DAY disease or condition resulting in death) **Examiner** Due to (or es a consequence of) by Physician/Medical Examiner DISEASE ARTERY 5 YEARS LORONARY The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 10 YEARS Box 68760. HYPERTENSION the Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 10 3 Probably 4 Unknown THEROSCLEROSIS 24b. Were eutopsy findings eveilable prior to completion of cause of death? Completed 24e. Wes en autopsy performed? DISORDER After this certificate hes 1 ☐ Yes 2 ☑No 1 ☐ Yes 2 DkNo is after death.

It Director: After this certificated in by the funeral director, pages and in by the funeral director, pages and in the funeral director, pages and in the funeral director, pages and in the funeral director, pages and in the funeral director, pages and in the funeral director, pages and in the funeral director, pages and in the funeral director, pages and in the funeral director, pages and in the funeral director, pages and in the funeral director, pages and in the funeral director, pages and in the funeral director, pages and in the funeral director. 25. Wes case referred to medical Medical Certification: To Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) BOARDING 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deeth MOME 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital of within 24 hours at To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred et the tima, date end placa, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner stated. 29a. Certifier (Check only one) 29b. Signeture and fitle of certifier 29c. License number 29d. Date signed (Month, Day, Year) eth, M.D. 28/99 0 33 407

Registrar

State

AUG 0 3 1999

31. Dete filed (Month, Day, Year)

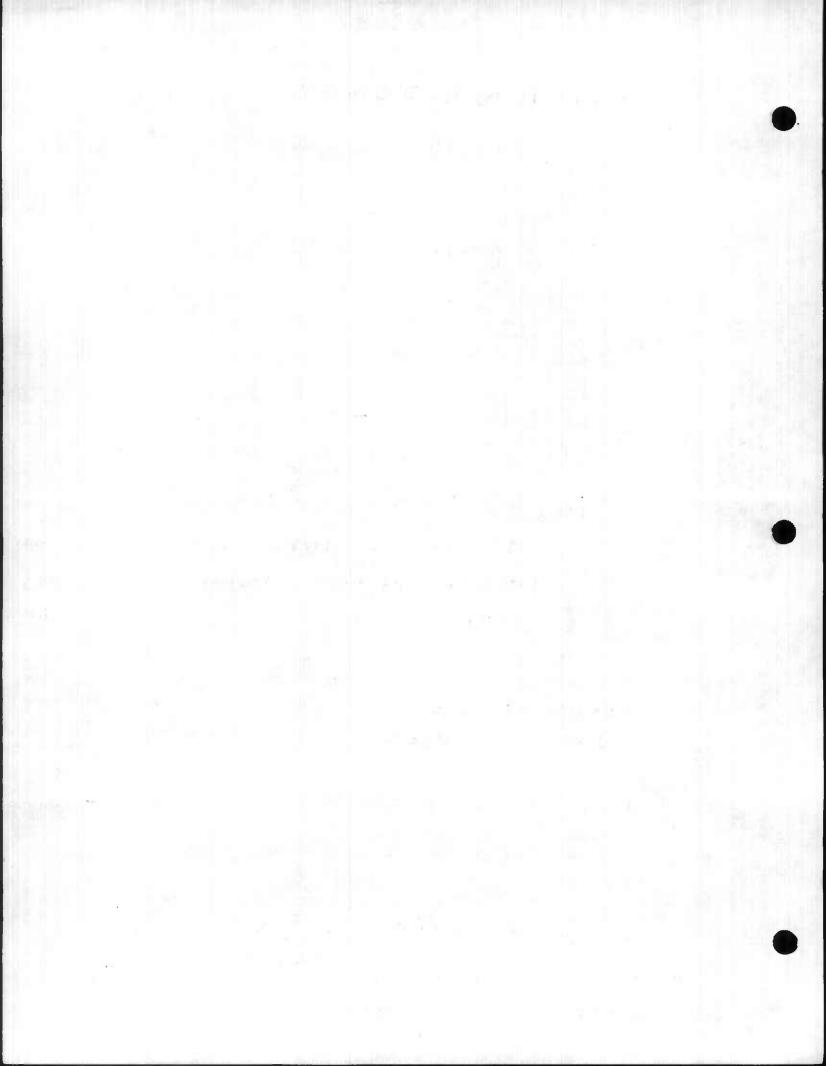
32. Regisfrar's Signeture

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DEEPAK SETH, 5411, OLD FREDERICK ROAD

SUITENIS

BALTIMORG



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible

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Phys	sician edical	1. Decedent's Nem	A		OHNSON					2	2. Dete of De Month JULY	Day	Year 99	3. Time of Death 13:29 PM
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Funer Direct	_	5. Social Security N 215-26-6 Usual Residence of	332	Sex 1XDM 2□F	7. Aga (In yrs. las 70	t birthday) Yrs.	If Under Months	1 Yaar Days	If Under Hours	Min.	B. Date of Bir (Month, De Oct. 2	th ey, Year) 3,1928	9. Birthpi Coun W. V	lece (Stete or Foreig try) IRGINIA
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170 128a	Director	10e. Street and Nu		/ //		ALITI	10f. Zip	Code				10g. Citizen	of What Coun	try?
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5-0020 72 hours after of natural, or them sicel Examiner.	by Funeral	11. Maritel Stetus 1 ☐ Never Men 3 ☐ Widowed	ried 200 Merried	Armed For	ces? 2 ☐ No		If Yes, spec		Specify:	i, Puarto Ri	ify Yas or No can, etc.)	Spe	llack, White,	etc.
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Vient Wents	0	JOSEPH	EDWARD	JOHNSON					NAON	MI CAT	THERIN	E RHODEHEAVER		
ary and a support	19e. Informent's N	lame/Ralationship	(Type, Print)		19b. Mellin	ng Address	(Street	and Numbe	er or Rural I	Route Numb	er, City or Tox	vn, State, Zip	Code)	
G. 30 00 to		BETTY LO	U TUREK/	SISTER		1688	POLES	RO	AD, BAI	LTIMOF	RE, MD.	21221		
Or and the		20e. Method of Dis	sposition			e of Dispo	sition (Name	na of thar ple	oe)		Date	20c. Locatio	n - City or To	wn, Stata
Pag Pag mt: III			5 Other (Spec		tata		IT CEM			8/2/9	99	BALTI	MORE, M	n
Baltimore, semit. Pages 1 a Department of Hea mportant: If Ilsen iny Injury or othe	ń	21. Signature of Fu	unerel Service Lice	ensee	UNLL	22	2. Neme en	d Addra	ss of Fecilit	У			TOKE OF	D .
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687 ifficate g phy as the	8	resulting in death)	Last		Due to (or es	s a conseq	uance or):							
Box 68 eath certific attending p	3			d									-	
death certificate attending physical for use as the	<u>S</u>	Pert II. Other signif	ficent conditions	contributing to des	ath but not reculti	og in the u	nderhring	auca aix	en in Pert I		23h Did	tobacco use	contribute to	the cause of death
P.O. that the detached	by Physician/M	Torris. Other eight	incant conditions	contributing to dee	an out not resum	ig in the d		ause giv	GI RI POILI			Yes 2 N		4/
requi	Completed t										24a. Was perto	en autopsy ormed?	COI	ere autopsy findings bilable prior to mpletion of cause death?
	Eo										10	Yes 2 No	10	Yas 20 No
Vital Insident The certificate irector, pa	Be	25. Was case refer	rred to medical						26 Place	of Deeth /	Check only			1
Of Vita Physician: this certific ral director,	To B	examiner?		Hospitel:	patient 2 EP	VOutpatier	nt 3 DC	Oth	er.	-		dence 6 🗆	Other (Snecih	v)
Physerthis eral di	n: T	27. Manner of Deet	th	28a. Dete of	Injury 28	3b. Time of				1		how injury oc		
ith. After	to	1 MNatural	5 Pending investigeting		, Day Year)	Injury	М		c. Injury at Work? 1 Yes 2 No					
Division or Attending after death. Director: After d in by the fune	Certification:	3 Suicide	6 Could not determine	28e. Plece o	of Injury - At home	e, ferm, str	eet, fectory	, office		28			mber or Rura	l Route Number,
Die Berger	-t-	4  Homicide	00.01111110	building	g, etc. (Specify)		,				City or To	wn, Stata)		
Division of Vita ospital or Attending Physician: hours after death.  Uneral Director: After this certific by filled in by the funeral director,	Sec	29a. Copiler	1□ Certifying P	hysician: To the b	est of my knowle	dge, deeth	occurred	at tha tir	na, data an	d place, sn	d due to the	cause(s) and	mannar as st	ated.

State Registrar

AUG 0 3 1999

32. Registrer's Signetura

who completed causa of deeth (Item 23a) (Type, Print)

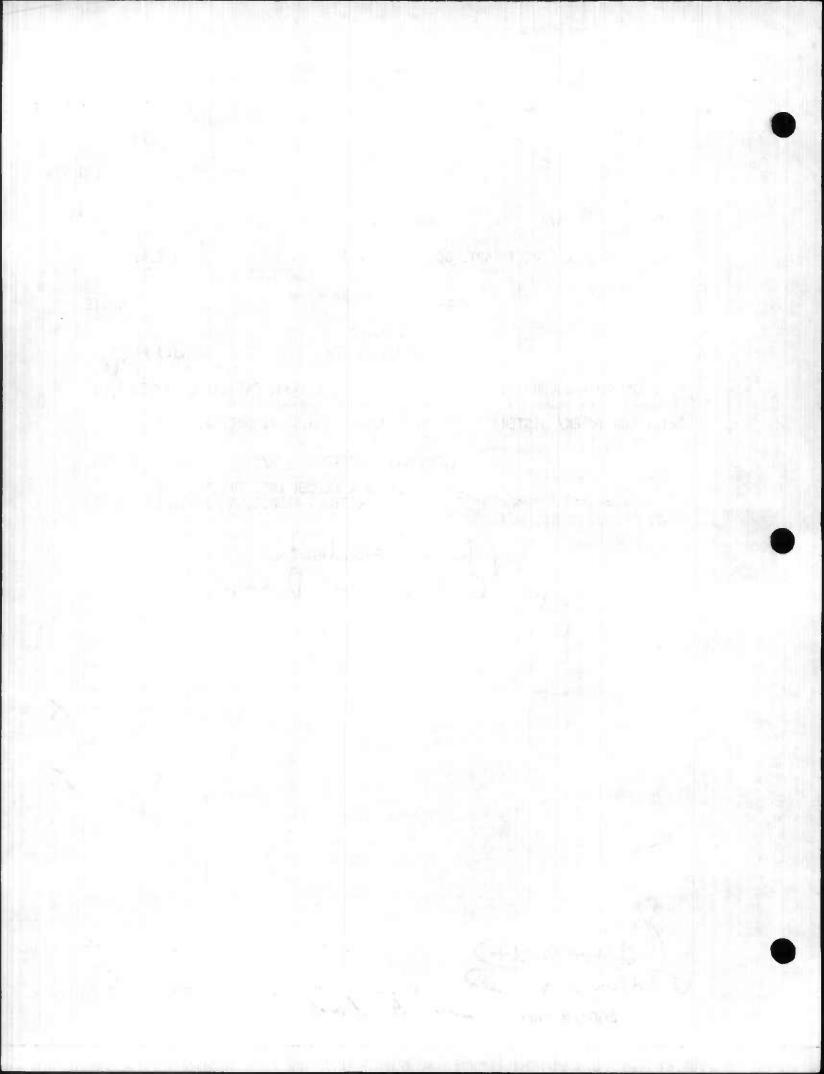
111 Penn Street, Baltimore, Maryland 21201

29c. License number

OCME

29d. Dete signed (Month, Day, Year)

JULY 31, 1999



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Physician
/Medical
Examiner

NOAH **TYRONE** JOYCE 4a. Facility Neme (If not institution, giva street and number) Peninsula Regional Medical Center

1. Decedent's Name (First, Middla, Last)

July

2. Date of Death 1999 4:43 A.M. 07

4b. City, Town, or Location of Death Salisbury

4c. County of Death

**Funeral** Director

"natural", or items 23a or 28a-f show

th end Mental Hygiene.
7 is marked other than "natur traumatic event, the Medical

. Peges 1 and 2 should be fill ment of Heelth end Mental Hant: If Item 27 is marked oth jury or other traumetic even

permit. Pege Depertment of Important: If any Injury or once.

**Physician** /Medical

Examiner

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signed by the at 1 be detached for

page 2 certificate

director.

filled in by the

Hospital or Attending Physician: 7 24 hours after deeth. Funeral Director: After this certifica

within 24 hours a

pue

The law requires that the death certificete be executed

Box 68760.

P.O.

Division of Vital Records,

Examiner

Physician/Medical

þ

Completed

Be

Certification: To

Directo

Completed by Funeral

Be

death with the Maryland

illed within 72 hours efter

21215-0020

Baltimore, Maryland

220-66-4395 Usual Residence of Decedent 10e State Maryland Wicomico

5. Sociel Security Number

M 2□ F

Eden

7. Age (In yrs. last birthday) 42 yrs. Months Days Hours Min. (Month, Day Year) 45 Salisbury, MD 9. Birthplace (Stata or Foraign

Wicomico

10b. County 10c. City, Town or Location

10d. Inside City Limits 1 Yes 2 No

Month

10e. Street and Number

10f. Zip Code 21822

10g. Citizen of What Country?

USA

4131 Allen Road

11 Marital Status 1 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedeni Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:

14. Raca - American indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highast grade complated)

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

Elementary/Secondary (0-12) 9th (GED)

17. Father's Name (First, Middla, Last)

College (1-4or 5+) laborer

Farming

Date

18. Mother's Name (First, Middle, Maldan Sumama)

PAUL

CHANDLER

DEL ORES

JOYCE

19a. Informent's Name/Reletionship (Type, Print) Naushell Birckhead/sister

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code)

Colimbury Maryland 21801 6364 White Cove Dr. - Salisbury, Maryland

22. Name and Address of Facility 1213 Jersey Road - Salisbury,

20a. Method of Disposition

1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Placa of Disposition (Nama of camatary, cramatory or other place) Friendship UM Church Cem.7/17/99 Allen

20c. Location - City or Town, Stete

21. Signature of Funeral Servica License

JOLLEY MEMORIAL CHAPEL 23a. Fert1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

immediete Ceuse (Finel disease or condition resulting in death)

GUNSHOT WOUND OF BACK OF CHEST

Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Lest

Due to (or as a consequence of):

Due to (or as a consequence of)

26. Place of Death (Check only ona)

23b. Did tobacco use contribute to the cause of death?

Yes 2□No

1 Yee XX No 3 Probably 4 Unknown

24a. Was an autopsy

24b. Were eutopsy tindings eveilable prior to completion of cause of death?

TXYes 2□ No

25. Was case referred to medical 1XXYes 2□ No

28a. Date of injury (Month, Day Year)

28b. Time of injury

28c. Injury at Work?

Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 28d. Describe how injury occurred SUBJECT WAS SHOT

27. Manner of Death 1 Naturei 2 Accident 3 Suicide 4 Homicide

5 Pending investigation 6 Could not be determined

7-7-99

Pert ii. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert i.

1 ☐ Yes 2 📆 🐪 0 UNK 28e. Place of injury - At home, ferm, street, factory, offica building, etc. (Specify)

28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) POPLAR STREET

29a, Coldman

FRUITLAND, MARYLAND STREET 1 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date end placa, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated.

Medical 29b. Signat

29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) JULY 8, 1999

end eddress of person who completed cause of death (Item 23a) (Type, Print)

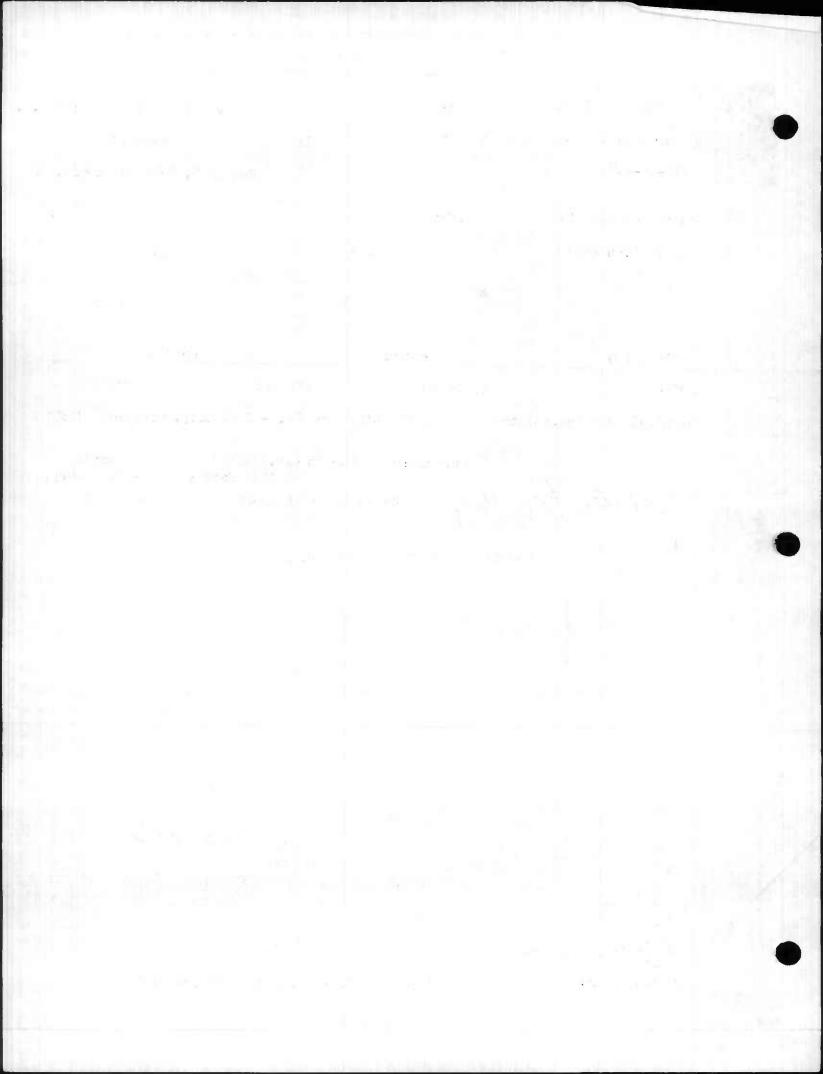
J. Laron Locke M.D.

111 Penn Street, Baltimore, Maryland 21201

State Registrar

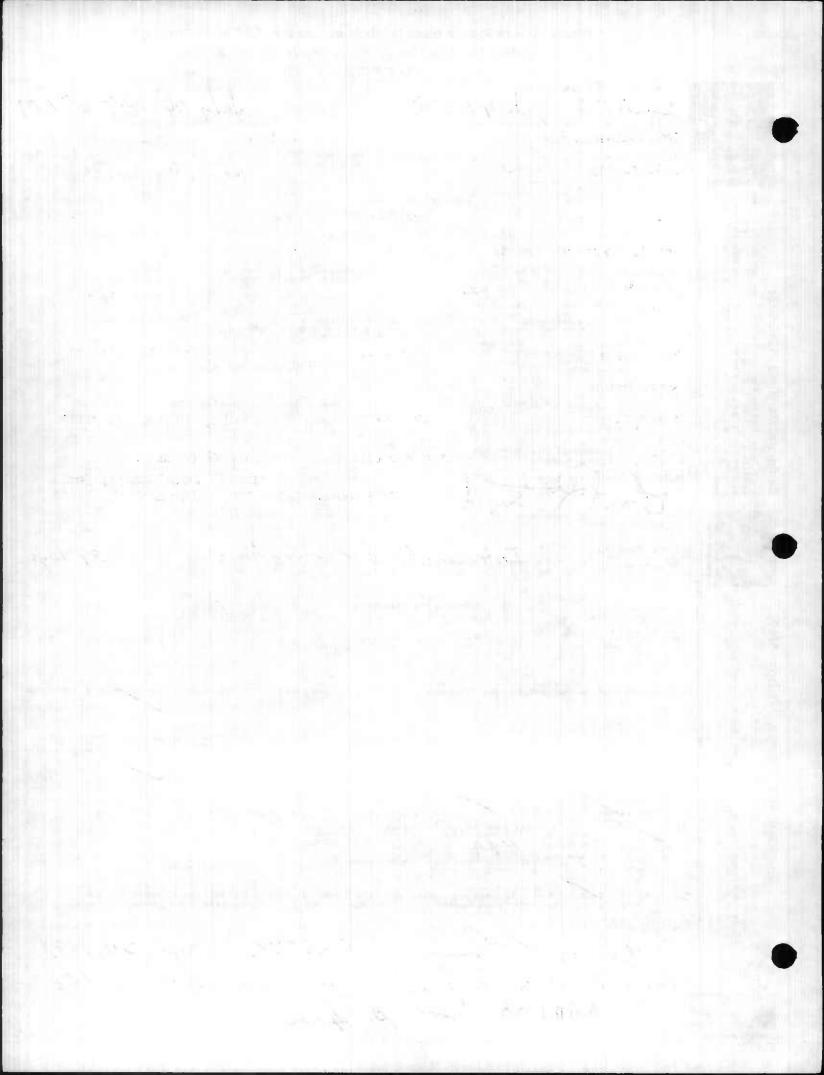
31. Date filed (Month, Day, Year) AUG 0 3 1999

22. Registrar's Signature



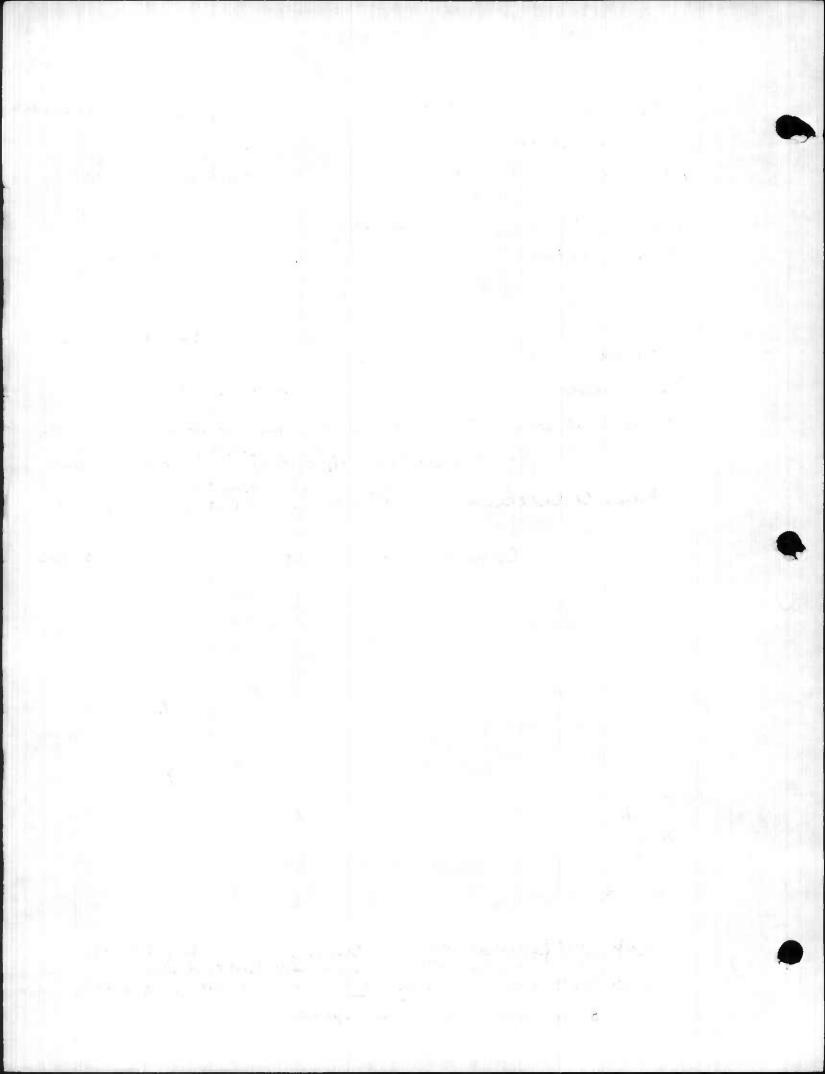
# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Data of Death Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

			Certific	ate of Death	Re	g. No.	24214			
Physician /Medical	1. Decedent's Name (First, Middle, L	JOYNE	R		2. Data of Death	24 199	3. Tima of Death			
Examiner	4e Facility Neme (If not institution, gi Levindale Hospit	iva straat and number)		Baltim		4c. County of D	eath			
Funeral Director	203-14-2847	Sex 1	s. last birthday) If Un Yrs. Monti	dar 1 Yaar If Undar 24 H hs Days Hours Mi		<sup>y</sup> ear) 9.1 1921 Pa	Birthplace (State or Foreign Country) 1.			
pue *	Usuai Rasidence of Decedanf  10a. Sfata  10b. County	10c. C	City, Town or Location	4			10d. Inside City Limits			
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th with the Mer 23e or 28e-f s in the motified	10e. Sfreef and Number 266 S. Monastery	Avenue	10f.	Zip Coda 21229	10	0g. Citizan of What USA	Country?			
d within 72 hours after deeth with the Manyland glane. The head of the manyland and the months of th	3 Nidowed 4 □ Divorced	12. Was Decedent Ever in Armed Forcas?  1 ☐ Yas 2 ☐ You If Yes, Give Yaer or Datas:	_	cedent of Hispanic Origin? specify Cuben, Maxican, Pures 2 Ano Specify:	(Specify Yes or No- erto Ricen, atc.)	14. Race - A Black, W Specify: P				
	15. Decedant's E (Specify only highast g		16a. Decedant's U (Give kind of	Isual Occupation work dona during most of w T usa retired)	rorking	16b. Kind of Busina	ss/Industry			
filed within 72 ho Hygiene. ort, the Medical	Elemantary/Secondary (0-12) 12th Grade	Collega (1-4or 5+)	Homemake:		P:	rivate Fa				
	17. Fathar's Nama (First, Middla, Las	0		18. Mothar's N	ame (First, Middla, N	faidan Sumama) u	nknown			
d 2 d d 2 s d d d 2 s d d d d d d d d d	19a. Informant's Name/Relationship Wyman Joyner	(Type, Print) SOn		ass (Street and Number or Ler Oaks Trai						
of Hear	20a. Method of Disposition  1 Durial 2 Cramation 3  4 Donation 5 Other (Spec	Ramoval from State	Place of Disposition (comatary, cramatory)	Nama of or other place)		20c. Location - City	or Town, Stata			
permit. Pages Department of Important: If it any injury or o	21. Signatura of Funest Service Co.	nsee E		end Address of Facility N						
Physician /Medical Examiner	23a. Parth. Enter the disease, or conshook, or heart failure. List only immediate Cause (Final disease or condition rasulting in death)	. Intrace		hemorn		ist,	Approximate fintarval Batween Onset end Deeth			
certificate be executed uding physician and use as the buriel-transit		bDue to	(or as a consequence	ance of):						
E 50 X	rasulting in daath) Last	C. Dua to (or es a consequence of):								
etter for class					001 0110					
d by the detached		contributing to death but not re	asulting in tha undarlylr	ng ceuse given in Part i.	236. Did to		offe to the cause of death? ☐ Probably 4☐ Unknow			
aw requires us been sign 2 should be					24a. Was ar perform		b. Wara autopsy findings available prior to completion of cause of death?			
					1 ☐ Ya	s 2000	1 Yas 2 No			
ysicien: The secondificate director, par	25 Was case referred to particul			26. Placa of D	eath (Check only on	a)				
	1 Yas 2 No	Hospital: 1 Inpatient 2	□ ER/Outpatient 3□		Homa 5 ☐ Raside		Specify)			
Attending Physic of death.  •ctor: After this by the funeral diffication: To		28a. Data of Injury (Month! Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Dascribe ho	ow Injury occurred				
tal or Attending P is after death. al Director: After led in by the funers Certification:	3 ☐ Suicide 6 ☐ Could not defermine			tory, office	28f. Location (St City or Town		r Rural Routa Number,			
hou hou line iy fill		hyelcian: To the best of my kr miner: On the basis of examination and mannar stated.	nowladga, daath occurr nati <i>on</i> and/or Invastigat	red at the time, date and pla lion, in my opinion, death oc	ce, and dua to tha ca curred at the fima, da	ausa(s) and manna ate and piace, and	r as stated. dua fo the ceusa(s)			
within 24 To the Fu complete				29c. Licanse number	25	9d. Data signed (M	onth, Day, Year)			
F 5 F 0	Bains	48obs		045872	2 0	July 2	4,1999			
JJ 3	30. Name and address of person who	complated ceusa of death (Its	am 23a) (Type, Print)	Rocode	idu	mf.	21136			
State	31. Data filed (Month, Day, Year)	32. Registraris Sign	natura 4	-1-						



## Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Marvland / Department of Health and Mental Hygiene

				Otate of IVI	arylanu / L	Certificate o		weritat n	Reg. No.	5 4	4215
	ıysici: Medic	_	1. Decedent's Name (First, Middle, Las	t)	Kirs	ch		2. Date of D Month	Dey	Year 1999	3. Time of Death
	kamin	_	4a. Facility Neme (If not institution, give	street end number)			4b. City, Town, o	r Location of Dee	th 4c. County		1 12 0 0 11 1
			Keswick Multicare	2 Center			Baltin	10/20		N/A	
Fun Dire	neral ector		213-20-9004 A	9x 7. Ag □ M 2X F	ge (In yrs. last bir 89	thday) If Under 1 Yea Months Dey	ar If Under 24 Hr	S. 8. Dete of B	rth ey, Yeer) 1910	9. Birthple	ace (Stete or Foreign ry) ryland
and w	-		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location				10	d. Inside City Limits
Mary	pag	rol	Maryland N/A			Paltimoto					1X Yes 2 No
the r 28a	noti	Jec.	10e. Street and Number			Baltimore 10f. Zip Code			10g. Citizan of V	Vhat Count	ry?
h with	St.De		713 N. Kenwood Av	enue			21205		II.	S. A.	
after deal or Itams	Examiner must be notified at	Funeral Director	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Armed Forces? 1  Yes 2 X		13. Was Decedent of If Yes, specify Cu	Hispanic Orlgin? ( ban, Mexican, Pue	Specify Yes or N onto Rican, etc.)	0- 14. Race Blace	e - America k, White, e	in Indien,
15-0020 72 hours aft	LExa	d by	3 X Widowed 4 □ Divorced	Year or Dates:		10165 22514	о эрвину.		Specify	Whi	te
212 d withir giene.	Ine M	Completed	15. Decedant's Ed (Specify only highest gred Elementary/Secondary (0-12) 12th Grade	ucation de completed) Collage (1-4or !		Decedant's Usual Occ (Give kind of work don life. DO NOT usa ratio	e during most of w	orking	Communia	ty Col	llege
ind be file doth	Nem H	Be	17. Father's Nama (First, Middle, Last)				18. Mother's Na	ama (First, Middle	e, <i>Maiden Sum</i> am	Θ)	
Maryland d 2 should be file h and Mental Hy 7 is marked othe	traumatic event,	2	Rudolph Benesch					tha Bene			
C 2 2 20	9		19a. Informant's Name/Ralationship (7			Mailing Address (Stra					
or Healt	y or other		Robert C. Wolf ( 20a. Method of Disposition  1 X Burial 2 Cremation 3 1 4 Donation 5 Other (Specify	Removal from Stata	20b. Placa of cometer	220 Lawnvic Disposition (Name of y, cremetory or other p	ace)	8/2/99			
Baltimoperant Page	any injury once.	1	21. Signature of Funeral Service Licens		Hebreu	Friendshi 22. Name end Add		ry	Baltimor	le, Mo	vryland
Balti permit. Departm imports	any ir		Buin City	1 - 00		Schimunel	z Funeral				
		$\dashv$	23a. Part1. Entar the disease, or comp	lications that causad	the death. Do r	3331 Bre	ums Lane,	Baltimo ac or respiratory	re, Mary	lland	21213 Approximate
Physic	cian		shock, or heart failure. List only o	ne causa on each li	ne.		, ,	,			Intarval Batween Onset end Death
/Medi	lical	Н	Immediate Causa (Final disease or condition	Coal	revaso	1)	ident			į	2 60
Exami			resulting in death)	a. CEIGI	Dua to (or as a		-19671			1	2 WEEKS
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68760, ficate be ex	the the	edicai	that Initiated events resulting in death) Last		Due to (or as a c	onsequence of):					
- E	co I			d							
death certi	for	clar							_		
- 0 0	detached	Physiclan/M	Part II. Other significant conditiona co	ntributing to death b	ut not resulting in	the undarlying causa	given In Part I.		V		the cause of death?
IS, P.O. es that the igned by th	det.	by P						1	Yes 2 No	3 Proba	ably 4 Unknown
aw requir	2 should b	Completed b							s an autopsy ormed?	avai	re autopsy findings ilable prior to aplation of causa eath?
The is	page	E						10	Yes 2 No	10	Yes 2□ No
VITAI Vician: Th	0	Be	25. Was case referred to medical				26. Placa of De	eath (Check only			
<b>-</b> 5 .9 ¹	6	0	examinar?	Hospital: 1   Inpatie	nt 2 ER/Ou	tpatient 3 DOA	thar: 4 Nursing	Home 5 ☐ Res	Idence 6 Othe	er (Specify)	)
fing Affer			27. Manner of Death  1 S Natural 5 Pending 2 Accident investigation	28a. Data of Inju (Month, De		ima of 28c. Injury W	ury at ork? Yes 2 No	28d. Describe	how injury occurr	ed	
DIVISION  be or Attending rs after death.  el Director: After	ed in by th	Certification:	3 ☐ Sulcide 6 ☐ Could not be 4 ☐ Homicida detarmined	28e. Place of Injude	ury - At homa, far c. (Specify)	rm, street, factory, office	9	28f. Location City or To	(Street and Number wn, State)	er or Rurel	Route Number,
DIN To the Hospital or I within 24 hours after To the Funeral Dire	pletely fill	edical	29a. Certifiar (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the bast of ner: On the basis of and manner sta	axamination and	daath occurred at the Vor Invastigation, in my	tima, data and place opinion, death occ	ee, and due to the curred at tha tima	cause(s) and ma data and placa, a	nner as sta ind due to i	ited. the causa(s)
To the Within 2	COM		29b. Signature and title of certifier		1		nse number		29d. Date signed		
			P Could way	Cosenha	Y MD	D3	025		Dugust	1,19	99
10	/		30. Name and address of person who co	omplated cause of d	eath (Itam 23a) (	Type, Print) Co.r	la wolf	Rosenth	aly Mis.	133	
1			5533 North	Calvert	street,	Type, Print) Car Sulte325	Baltim	ore Mo	ryland	212	8
Reg	Stat gistra	<b>-</b>	31. Data filed (Month, Day, Year)		Signatura	B. 1	rocks	*	•		



GEORGE F. KEFFER

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No.

Physician /Medical Examiner
Funeral

ahow mast be notified at Funeral Directo Herra: by

death with the Meryland

**Physician** /Medical Examiner The law requires that the death certificate be executed Box 68760, tha for usa as P.0.

permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Hastit and Mental Hygiena. important: if flem 27 is marked other than any injury or other trainments. Division of Vital Records, this cartificata has To the Hospital or Atlanding Physician: within 24 hours after death.

To the Funeral Director: After this cartifical completally filled in by the funeral director, 10 State

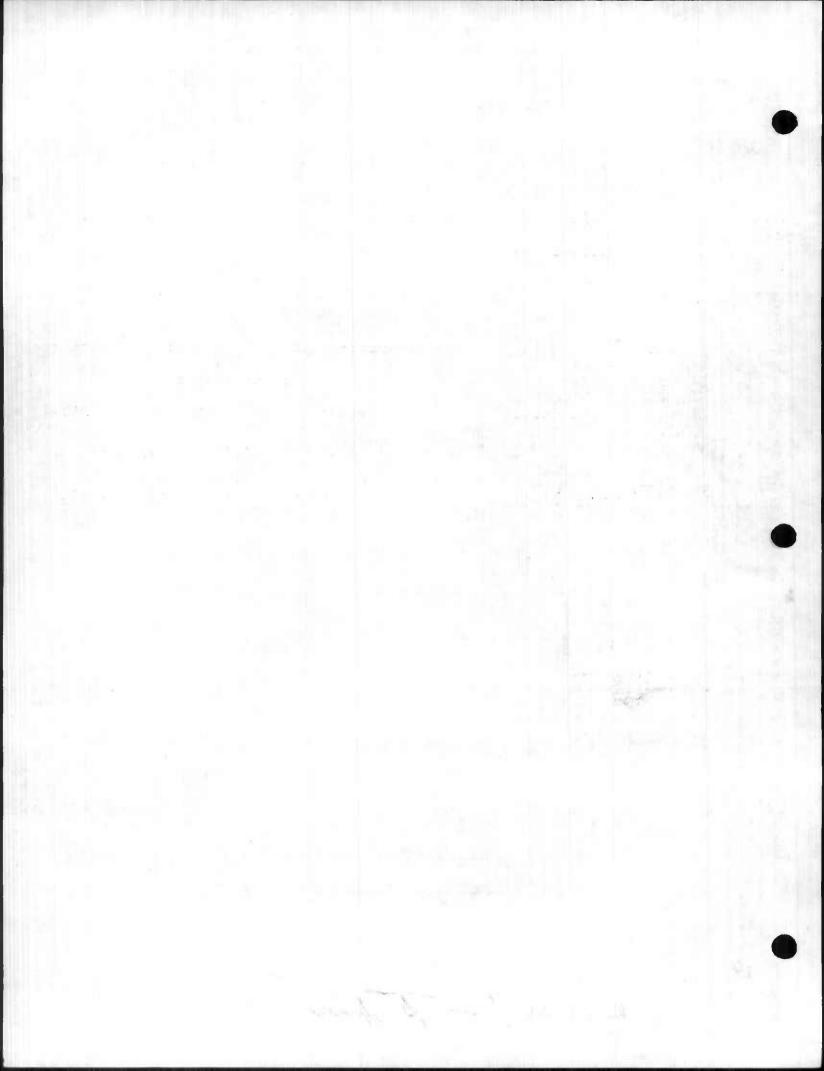
1. Decedent's Name (First, Middle, Lest) 2. Date of Death 31, 1999 Year Month JULY 0615 AM George F. Keffer, Sr. 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death WHITE MARSH MALL WHITE MARSH BALTIMORE If Under 1 Yeer | If Under 24 Hrs. Hours | Min. 5. Social Security Number 8. Dale of Birth (Month, Day, Year) May 7 1931 9. Birthplace (State or Foreign Country)
Md. 7. Age (In yrs. last birthday) 1₺ M 2□ F 215-28-2775 68 May Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1☐Yes 2☐No N/A Baltimore, Md. Md 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 3025 Oakcrest 21234 USA Avenue 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Black, White, atc. 1 Never Married 2 Merried 1 ☐ Yes 28 No Specify: If Yes, Give Year or Dates: KOREAN Specify: 3 ⊠Widowed 4 □ Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Coilege (1-4or 5+) N/A 12th Superintendant City of Baltimore 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Frank Keffer Jennie Brandt 19a. Informani's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 35 Springtime Way, Baltimore, Md. 21234 George F.Keffer, II 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burlei 2 ☐ Cremetion 3 ☐ Removei from Stete 8/3/99 Parkwood Cemetery Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hartley Miller Funeral Home, CHTD. ,00, 7527 Harford Rd. Baltimore, Md. 21234 23a. Part I Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. Left only one cause on each line. Approximeta interval Between Onset and Deeth immediate Cause (Final disease or condition resulting in deeth) . Atheroscleratic Cardiovascular Disease Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated eventa resulting In death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Wera autopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed? Limited 1. Yes 2□No UNYes 2□ No Be 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence ADOther (Specify) AT SCENE Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury al Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner es stated.

\*\*Comparison of the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and menner stated. Medical 29e. Certifier (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) O.C.M.E JULY 31, 1999 30. Name and address of person who completed cause of deeth (Item 3a) (Type, Print)

Street, Baltimore, Maryland 21201. Radentz Stronen S.
31. Dale filed (Month, Dey, Year) 32. Registrer'a Signatu

Registrar **DHMH 16 Ray 6/95** 

AUG 03



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

24217

												Reg. No.				
Physician		I. Decedent's Name (F	irst, Middle, La					111			2. Date of D	eath Dey	v	Year	3. Time of	Death
Physician /Medical		Annie			mon						JULY	30,	199		0635	AM
Examiner		GOOD SAM				•		4	BAL'I		cation of Dea	ith 4c.	County N/A	of Death		
Funeral Director	5	Social Security Number 215-92-2		Sex 1□M 2∏ F	7. Age (In yr 9.5	s. last birthday Yrs.	Months	Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, D 03-2	lay, Year)		9. Birthp Coun SC	lace (State o	r Foreig
		Jsual Residence of De				20. 20. 4										
or 28a-f show be nothing at Director		MD 10	NA			City, Town or E								31	0d. Inside Cit ty∏ Yes	
23a or 2 art be no	1	4915 Ca		a Road				p Code 1214	1				USA	Vhat Coun	itry?	
al, or hems 23s or 28s-f show Exercises must be notfled at by Funeral Director	2	1. Marital Status 1 ☑ Never Married 3 ☐ Widowed 4 ☐	- A C	Armed F	2€ No	U,S. 13.	Was Dece If Yes, spe 1☐ Yes	ecity Cuba	ispanic Ori in, Mexicar Specify:	gin? (Sp n, Puerto	ecify Yes or N Rican, etc.)		Blac	e - Americ ck, White,	etc.	
ygiene. Ner than "natural", It, me terdine En	Date:	(Specify o	-	ade completed)		16a, Dece (Give	edent's Usu e kind of wo DO NOT u	el Occup ork done i use retirec	ation during mos	t of work	ing	16b. Ki	ind of Bu	usiness/Inc	dustry	
the state		Elementary/Seconda 10th Gra		College (	(1-4or 5+)		stic		,			va	rio	us t	rade	s
I D E _		7. Father's Name (Firs							18. Mothe	er's Name	(First, Middl	e, Maiden	Sumam	10)		
arked off atto ever		Jim	Lemo	on	Annie						Br	own	1			
27 la m r traum	1	19a. Informant's Name Ella	/Relationship (		,					er or Rural Route Number, City or Town, State, Zip Code) Road Baltimore, Maryland 21					212	
y or it	2	0a. Method of Disposit 0C Burial 2 □ C 4 □ Donation 5 □	remetion 3			Place of Disp cometery, cre Voshel	ametony or a	other plan	e) Garde	ens	Date 08-04			City or To		
Departmen Important: eny Injury phos.	2	21. Signature of Funera	2000	22. Name and Address of Facility Baltimore, Maryland 2120 WM.C. March 1101 E. North Avenue								202				
ysician Medical aminer	li co	23a. Part1. Enter the d shock, or heart lai Immediate Cause (Fina disease or condition resulting in death)					nter the mod	de of dyin	g, such as	cardiac (	or respiratory	arrest,		1	Approximate Interval Bety Onset and D	e ween
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this certificate has been signed by the attending physician end in in in in it is if director, page 2 should be detached for use as the burlei-transit.  To Be Completed by Physician/Medical Examiner.	Delining P 2	immediate Cause (Final disease or condition resulting in death)  Sequentially list condition and the condition resulting in death)  Sequentially list condition and the condition of the conditio	to medical  To pending investigation determined  Could not be determined	b  c  d  bootributing to describe the position of the boots are also as a contributing to describe the position of the boots are also as a contribution of the boots are also as a contribu	Due to  Due to  Due to  Due to  Due to  Inpatient 37  of Injury Atling, etc. (Special posts of my loca	(or as a consector as	A the ropage of	OA Oth  OA Oth  OA Oth  OA Oth  OA Oth  OA Oth  OA Oth  OA Oth  OA Oth	g, such as  26. Place en in Part I  26. Place er: 4 □ Nu yer xer Yes 2 □	cardiac (	23b. Dic 1 Location City or To	d tobecco Yes 2 Sen autorformed? PECTI Yes 3 Yone) Sidence (Street an own, State e cause(s) s, date and	Usa cor  No  No  ON  ON  ON  ON  ON  ON  ON  ON	24b. Wood of 1 [2 and one or or Aura and due to	Approximate Interval Betwoen Conset and Expression of Expr	e ween Deeth Unknow Indings to ause No

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Please Type or Print in Black indelible lnk. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death AMEND#8 PER F.H. G7748-3-99 J.A 2. Data of Death 1. Decedent's Nama (First, Middle, Last) Month 4b. City, Town, or Location of Death 4c. County of Be Fecility Nama (If not institution, give street and number) Al ALTIMOR 8, Data of Birth (Month, Day, 5. Sociel Security Number 6. Sex 7. Aga (In yrs. last birthday) Birthpiace (State or Foreign 218-36-969 Usuei Rasidence of Dacedant Days Hours Min 1 □ M 200 F Yrs. 10a. Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No larvland mor 10g. Citizan of What Country? 10e. St/eet end Number 10f. Zip Coda O 12. Was Dacedant Evar In U,S. Armed Forces? Was Dacadent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Ricen, etc.) 14. Baca - American Indian 11. Meritei Status Black, Whita, atc. 1 ☐ Yas 2 No If Yas, Giva Yaar or Datas: 1 Navar Marriad 2 Married 1 ☐ Yas 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedant's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Coileg® (1-4or 5+) Elamantary/Secondary (0-12) Vat d 17. Fathar's Neme (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden print) daughter 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 Yld. 2/201 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Ramoval from Stata ores 4 ☐ Donetion 5 ☐ Othar (Specify) 22. Nama and Addrass of Fegil a Joseph us uner Parti. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Deeth Immediata Causa (Final disaasa or condition rasulting in daath) days Dua to (or as a consequanca of) TICA Sequentially list conditions, if eny, laading to Immediata causa. Enter Underlying Causa (Disaase or injury that hittiated avants rasulting in death) Last Dua to (or as a consequence of): Dua to (or es e consequança of): 23b. Did tobacco use contribute to the cause of death? Part if. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. Pascelar disease 1 Yee 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to complation of causa of death? 24a. Was an autopsy 1 ☐ Yas 2FINO 26. Placa of Death (Check only one) Hospitat: Othar: A Nursing Homa 5 Residance 6 Othar (Specify) 1 Inpatiant 2 ER/Outpatiant 3 DOA 28d. Dascribe how injury occurred 28b. Tima of

permit. Pages 1 and 2.
Department of Health an.
Important: if item 27 is m. any Injury or other.
Ence. **Physician** /Medical Examiner

**Physician** /Medical

Examiner

**Director** 

ir than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

1 and 2 should be filed within 72 hours after Health and Mentel Hygiene. em 27 le marked other than "natural", or ite

I Hygiene.

other traumatic event,

Maryland 21215-0020

altimore,

Box 68760.

Division of Vital Records,

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To the Hospital o within 24 hours at To the Funeral Di

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27. Manner of Daath

29a. Certifiar

25. Was casa rafarrad to medical axaminar? 1 Yas 2 No

5 Panding invastigation + Natural 2 Accident

6 Could not be datarmined 3 ☐ Sulcide 4 Homicida

28a. Data of Injury (Month, Day Year)

Pieca of Injury - At home, farm, straet, factory, offica building, atc. (Specify)

28c. Injury at Work? 1 TYes

1 Certifying Phyalcian: To tha best of my knowladga, daath occurrad at tha tima, data and place, and dua to tha causa(s) and mannar as stated.

2 □ No

Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, end due to the cause(s) end manner stated. (Check only one) 29b. Signature nd title of certifier

29d. Daje signed (Month, Day, Year)

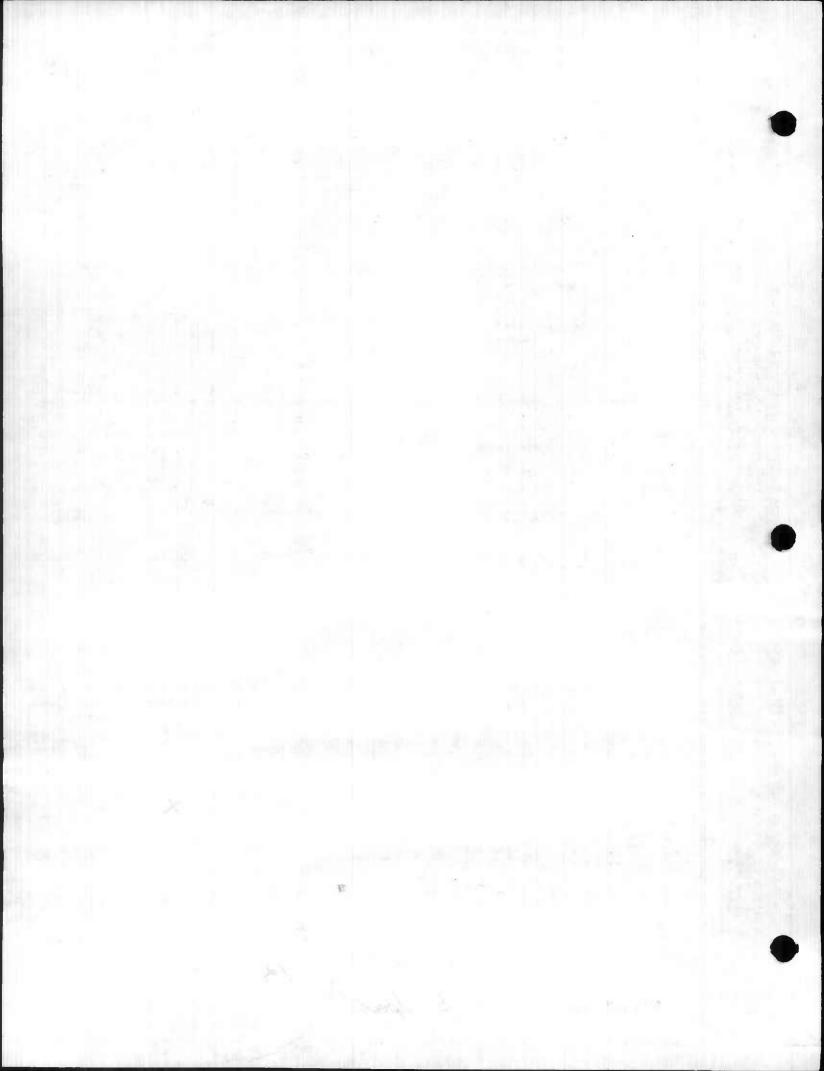
and addrass of parson who complated causa of death (Itam 23a) (Type, Prig nn

31. Data fitad (Month, Day, Yaar) AUG 0 3 1999

32. Ragistrar's Signatura

# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		,	Certifica	te of Death	R	leg. No. 9 9	24219					
Physician	Decedent's Neme (First, Middle, Last)				2. Date of Dea Month	th Day Ye	3. Time of Death					
Physician /Medical	MARY ANTOINETTE	LANASA			JULY 29		6 PM.					
Examiner	4e Facility Neme (If not institution, give sti				Location of Death	4c. County of E	Death					
	FUTURE CARE NORTH	CHARLES HEALT				N/	A					
Funeral Director	210-32-0200	7. Age (In yrs. Ia 92	Yrs. If Und Months	er 1 Year If Under 24 Hr B Days Hours Mi		Year)	Birthplace (State or Foreign Country) Maryland					
g .	Usual Residence of Decedent  10a. Stete 10b. County	10c City	Town or Location				10d. Inside City Limits					
with the Marylai a or 28e-f show be notified at Director	Md. n/a		altimore				1 X Yes 2 No					
or 28e-f s be notified Director	10e. Street and Number		10f. Z	ip Code	1	log. Citizen of What	t Country?					
w di maria	18 E. Cross Street			21230		USA						
her des finar m	11. Merital Stetus 12 11 Never Married 2 Married 3 Widowed 4 Divorced	2. Wes Decedent Ever in U,S Armed Forces? 1 Yes 247 No If Yes, Give A Year or Dates:	3. Wes Dec If Yes, sp 1 ☐ Yes	edent of Hispanic Origin? ecify Cuban, Mexican, Pue	(Specify Yes or No- orto Rican, etc.)		Vinerican Indien, Vinite, etc. White					
Maryland 21215-0020 d 2 should be filed within 72 hours at this and Markel typical and the state of the than "autural", or traumatic event, the Medical Exam To Be Completed by F	15. Decedent's Educa		16a. Decedent's Us			16b. Kind of Busine	ess/Industry					
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Be Garage	17. Father's Neme (First, Middle, Last)				ame (First, Middle,							
Wild b Wi	Stefano Lanasa			Rosin	a Sansone	9						
and of another and of another and of another and of another and of another and of another and of another and of another and of another ano	19a. Informant's Neme/Relationship (Type	e, Print)	19b. Mailing Addre	ss (Street and Number or I	Rural Route Numbe	r, City or Town, Sta	te, Zip Code)					
N. 10 CT W	Josephine Uher	(Sister)	1 W. Co	nway Street	Apt. 915	Baltimore	e, Md. 21201					
SAILLMOICE, semil. Pages 1 a Separtment of Heamportant: if learn my injury or other pice.	20e. Method of Disposition	COL	ace of Disposition (N	ame of other place)	Date	20c. Location - City	or Town, Stete					
Page mental my or	1 ☐ Burial 2 ☐ Cremetion 3 ☐ Rei 4 ☐ Donetion / 5 ☐ Other (Specify)	movel from State	en Mount		7/31/99	Baltimore	e. Md.					
a production of	21. Signature of June rel Service Licensee			and Address of Facility								
0 80 8 8	McCully-Polyniak Funeral Home P.A. 130 E. Fort Ave., Baltimore, Md. 21230											
	23e. Pert1. Enter the disease, or complication	ations that caused the death.	Do not enter the mo	. FORT AVE.,	Baltimor	e, Md. 2	Approximate					
Dhysisian	shock, or heart feilure. List only one	cease on each line.					fnterval Between Onset and Daath					
Physician /Medical	Immediate Cause (Final											
Examiner	Immediate Cause (Finel disease or condition resulting in death)  a. Celebral Minombos & sudded											
<u> </u>		Due to (or	es a consequence of	):			1					
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tricate be assected to physician and as the burial-transit fedical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or	as a consequence of	):								
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ifficate be g physicia as the bu	resulting in death) Last	Due to (or a	as a consequence of	):								
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death cert e attendin ed for use					I and more							
9 5 5	Pert II. Other eignificant conditions confr	buting to death but not result	ting In the underlying	cause given in Pert I.			oute to the cause of death?					
that the sed by detac				1 D Y	es 2010 3	3 Probably 4 Unknown						
0 8 5 8 0					24a. Was a	an autopsy 2	4b. Were autopsy findings					
					perfor		available prior to completion of cause of death?					
The law site has the page 2 s							of death?					
= F # 6 0					1 U Y	es 2ENo	1 ☐ Yes 2 Ø No					
ysician: The ysician: The director, pag	25. Was case referred to medical examiner?				eath (Check only or	ne)						
T dig	TLI Yes 2LTNO	spitel: 1   Inpatient 2   E	R/Outpatient 3□ 0		Home 5 Resid	College Harris	Specify)					
After the funeral funeral funeral	27. Menner of Death  1 □ Natural 5 □ Pending	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe h	28d. Describe how injury occurred						
Attanding or death.  ctor: After by the fune	2 Accident investigation		M	1 ☐ Yes 2 ☐ No								
DIVISION C lal or Attanding P is after death. In Director: After it ed in by the funera Certification:	3 Suicide 6 Could not be determined	28e. Pleca of Injury - At horn building, etc. (Specify)		ory, office		ation (Street and Number or Rural Route Number, or Town, State)						
Cert is a principle of the cert is a principle o												
To the Hospital or All within 24 hours after debug formpletely filled in by Medical Certifi	29e. Certifier 1 Certifying Physic (Check only one) 1 Medical Examine	cian: To the best of my know er: On the basis of examination and menner steted.	rledge, death occurre on and/or investigation	d at the time, date and pla n, in my opinion, death oc	ce, and due to the c curred at the time, d	ause(s) and manne late and place, and	or as stated. due to the cause(s)					
To the To the Comple	29b. Signeture and fittle of certifier		2	9c. License number	2	29d. Date signed (M	fonth, Day, Year)					
-170	160.00	alm		DICE 22		14/20	1999					
, N/	20 Name and street To	DUIT C	22a) (Tree Brief)	013010		1930	)////					
0 5	30. Neme end eddress of person who com		- 1	DIS872	dour	21126						
	HARRY BUB	32. Registrer's Signatu		1	, 0000)	01100						
State Registrar	31. Date filed (Month, Day, Year) AUG 03 1990	3.	Spark	2								



#### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24220 Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2 Date of Death Month **Physician** 31 10:15 PM July Roland S. Labatue /Medical 4b. City. Town, or Location of Death 4e Facility Name (If not institution, giva street and number) 4c. County of Death Examiner Mariner Health Care Center BelAir Harford if Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Yeer) Birthpieca (Steta or Foraign Country) **Funeral** Days Hours Min 1KM 2□ F Yrs. 85 Director 212-07-3961 10-30-1913 Md. Usuel Residence of Decedent with the Maryland 10e. Stata 10b. County 10c. City, Town or Location 10d. fnside City Limits ral", or items 23s or 28s-f show Examiner must be notified at 1X Yas 2 No N/A Md. Baltimore Directo 10e. Streef and Number 10f. Zip Code 10g. Citizen of What Country? 2927 Pulaski Highway pemit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. important: if item 27 is marked other than "natural", or items 23s any injury or other traumatic avent, the Modes Examine manal once. 21224 U.S.A. Funeral 12. Was Decedent Evar in U,S. Armed Forces? 14. Race - American Indian, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1)X Yes 2 □ No If Yes, Give Yaar or Dafas: WWII 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes > No Specify: Specify: White by 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grada completed) 16e. Decedent's Usuai Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8th Machine Operator West Va. Co., Co 17. Fether's Name (First, Middle, Last) Eugene Labatue Julia Cassidy 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Patricia Werner / Daughter 807 Foothill Ct. BelAir, Md. 21014 120b. Piace of Disposition (Name of Dete 20c. Location - City or Town, State 20e. Method of Disposition Ob. Place of Disposition (Name of cametery, cremetory or other pleca) 1 Buriai 2 Cremation 3 Ramoval from Stafa 4 Donetion 5 Other (Specify) Oak Lawn Cemetery 8-4-99 Balto., Md. 21. Signature of Funaral Servica Licensee 23a Pint. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, inock, or heart feilure. List only one cause on each line. Moran-Ashton-Dabrowski Funeral Home, Inc. 21224 Approximete Intervet Between Onsat and Death **Physician** · Left Henispheric Cerebrovaseular Accident /Medical Immediate Ceuse (Finel disease or condition resulting in death) Examiner Due to (or es e consequence of): Examine physician and the burial-trensit Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lesf Due to (or as a consequence of): Physician/Medical Dua to (or as e consequence of): 987 Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Coronary Artery Disease Division of Vital Records, þ 24b. Were autopsy findings evaltable prior to completion of causa of death? 24e. Was en eutopsy parlormed? Completed Atrial Fibrillation 1 Yes 2 ₽No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Piece of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Deeth 28e. Date of Injury (Month, Dey Year) 28d Describe how Injury occurred 28b. Time of 28c. Injury et Work? 5 Pending 1 Yes 2 No Investigation 2 Accident after deat Director: 6 Could nof be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Piaca of injury - At home, farm, sfreef, factory, offica building, etc. (Specify) 4 Homicide 24 hours e 1 🕒 Certifying Physician: To tha best of my knowledge, daafh occurred at fha tima, dafa and place, and dua to the cause(s) and manner es stated. 29a. Certifier To the Hosp within 24 hos To the Fune completely fi Medical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, end due to the cause(s) and menner steted. (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AUGUST 1, 1999 D35012

State Registrar **DHMH 16 Rev 6/95** 

Roland

J. Kevin Lynch RD 2 31. Dete fited (Month, Day, Year)

AUG 0 3 1999

30. Name and address of person who completed cause of deeth (Item 23a) (Typa, Print)

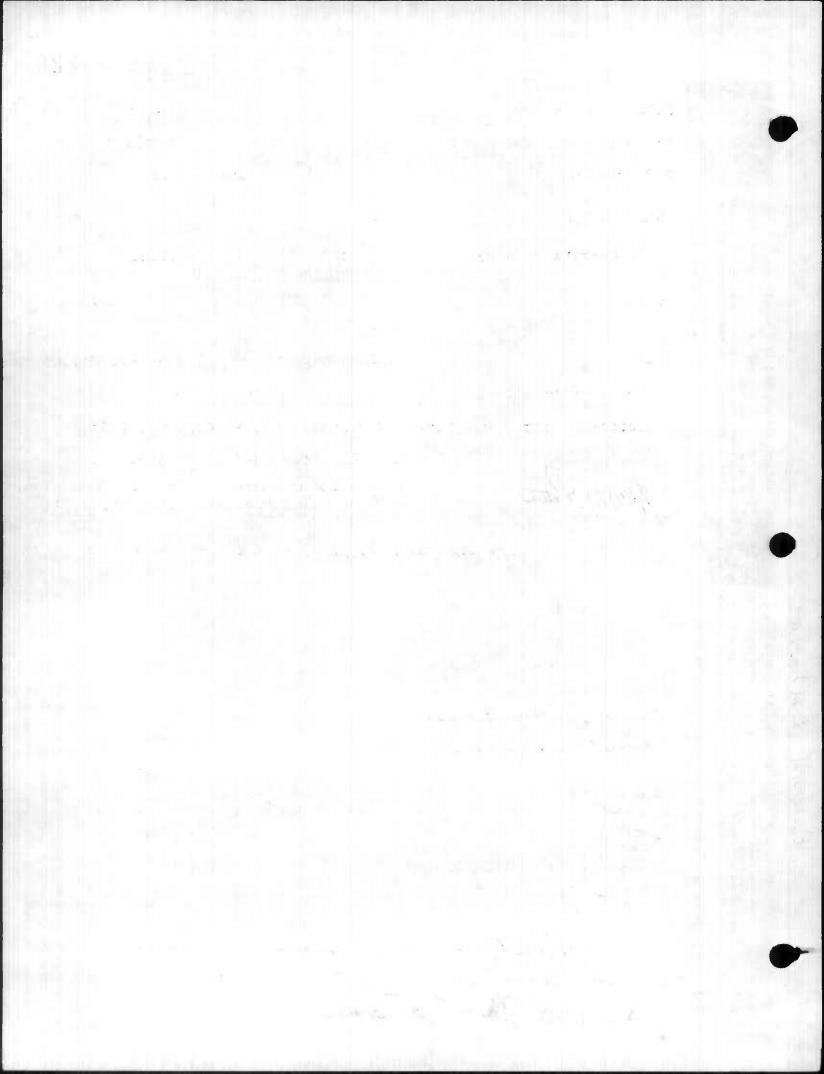
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32. Registrer's Signature

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Bel Air,

Md.



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Nama (First, Middle, Last) 3. Time of Death 2. Data of Death Month MARTIN CE @14 9:18 Au 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death If Under 24 Hrs. Numbe (In yrs. last birthday) 8. Date of Birthplace (State or Foreign 213-07-4056 100 M 2□ F Months Days Min Carolina Usual Residence of Decedent 10a State 10b Count 10c. City, Town or Location 10d. Insida City Limits Maryland Yas 2 No more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1528 06 0 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) Armed Forces? 1 Yes 2 No If Yes, Give Year or Datas: Black, White, atc. 1 Navar Married 2 Married 1 Yes 2 No Specify Hmerican 3 Widowed 4 Divorced 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. PO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Cóllege (1-4or 5+) ax Ne 0 18. Mother's Name (First, Middle, Meiden Surneme) 17. Fathar's Nama (First, Middle, Last) ame 19b. Mailing Address (Straet and Number or Flural Route Number, (niece Steta, Zip Coda) 19a. Informant's Name/Relationship (Type, City or Town (Pxint) 1d.21 20b. Place of Disposition (Neme of 20a. Method of Disposition Date 20c. Location - City or Town, State tery, cremetory or other piece) 1 Surial 2 Cremation 3 Removal from Stata 4 Donation 5 Other (Specify) 21. Signatu p of Funeral Service/Licenses 22. Name and Address of Facility Joseph The distance or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, but failure. List only one cause on each line. 121 Approximata Interval Batween Onset and Death Immediate Causa (Final · MyocArdial FN FACETION 15 mondat disease or condition resulting in death) Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disaasa or Injury that initiated evants resulting in death) Last Dua to (or as a consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 23b. Did tobacco uss contributs to the causs of death? 3 Probably 4 Unknown 1 Yss 2 No 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of ceuse of death? 1 Yes 2 NO 1 ☐ Yes 2 ☐ No 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28b. Tima of 28d. Describe how injury осситеd

Physician /Medical Examiner

Department of Healt fmportant: If Item 2 any injury or other

**Physician** 

/Medical

Examiner

Director

Funeral

P

Completed

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**Funeral** 

Director

Pages 1 end 2 should be filled within 72 hours effer death with the Meryland nent of Heatth and Mental Hygiene. nnt: If them 27 is marked other than "natural", or items 23s or 28s-f show

Baltimore, Maryland 21215-0020

7 is marked other than "natural", or items 23s or 28s-f show treumstic avent, the Medical Examine, must be notified at

Physician/Medical Examiner and I-transit ettending physician a for use es the buriel-

been signed by the should be deteched is certificate has t

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

funeral

þ Completed Be 2 Certification:

Hospital or Attanding Physician: To the Hospital or Attandir within 24 hours efter death. To the Funeral Director: All completely filled in by the fu edical

After this

death.

State Registrar 25. Was cese referred to medical examiner? 28a. Data of Injury (Month, Dey Year) 27. Manner of Death 5 Pending invastigation 1 Watural 1 Yes 2 No 2 Accident 6 Could not be datarminad 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide

1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceusa(s) end mannar es stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29a. Certifier (Check only one) 29d. Data signed (Month. Dav. Year) 29c. Licensa number

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2000

AUG 0 3 1999 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene g 24222 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** McBrid Month Q 15 AM Honie 7-31-99 /Medicai 4e. Fecliity Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner GOOD SAMARITAN HOSPITAL BALTIMORE If Under 1 Yeer | If Under 24 Hrs. | 8. Dete of Birth | Montha | Deys | Houra | Min. | 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral**  Birthplece (State or Foreign Country) 1 M 2KDÆ Deys Yrs. Director 099-20-6596 79 8-26-1919 SC **Uauel Residence of Dacedant** 10a. Stete 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10d. Insida City Limits Director 1XXYes 2 □ No MD. BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 501 E. PRESTON STREET 21202 Funeral U.S.A. deeth 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ACM If Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bieck, White, etc. should be filed within 72 hours after nd Mental Hygiene. marked other than "natural", or its 1 | Never Married 2 | Married 21215-0020 1 ☐ Yes 2 No Specify: Q Specify: 3 ☑ Widowed 4 ☐ Divorced BLACK Completed 16a. Decedent'a Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind ot Business/Industry Elementary/Secondery (0-12) Coilege (1-4or 5+) 12 HOMEMAKER HOME traumatic event, Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) permit. Peges 1 and 2 should be file Department of Heelth end Mental Hy Important: if Item 27 is marked other any lighty or other traumatic event poice. 18. Mother's Name (First, Middle, Maiden Sumeme) Be FRANK FURMAN EMMA JOHNSON 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, State, Zip Code) 441 E. 28th STREET BALTIMORE MARYLAND 21218 EMMA COTTON 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 □ Cremetion 3 □ Ramovei trom State 4 □ Donetion 5 □ Other (Specify) DRUID RIDGE CEMETERY 8-6-99 BALTIMORE. MARYLAND 21. Signeture of Funday Service Licensee 22. Name end Address of Fecility ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PLACE BALTIMORE MARYLAND 21217 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate intervei Betw Onset and Death **Physician** /Medical Immediate Ceusa (Finai CARDIAC ARRES [
Due to (or es a consequence ot): diseese or condition resulting in deeth) Examiner Physician/Medical Examiner the death certificate be executed shysician and the buriel-transit Sequantially list conditions, if any, iaeding to immedieta cause. Enter Underlying Cause (Disaasa or injury that initiated events resulting in deeth) Lest CAIPHERAL VUSCULAR DISEASE
Dua to (or as a consequence ot): Box 68760, DER JEMTON P.O. Pert il. Other significant conditiona contributing to death but not resulting in the undarlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 DOnknown The law requires that signed t Records, þ pege 2 should Completed 24b. Were autopsy tindings aveileble prior to 24e. Wes an eutopsy completion of cause of deeth? 1 Yea 2 DUNO 1 Yes 2 No of Vital or Attending Physician: 25. Wes case retarred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospital: 1 ☐ inpatient 2 DER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 70 1 Yes 2 No this 27. Menner of Deeth 28e. Data of injury (Month, Day Year) 28b. Tima ot 28c. injury et Work? 28d. Describe how injury occurred After Division 5 Panding investigation 1 Maturel 1 ☐ Yes 2 ☐ No within 24 hours efter death To the Funeral Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28a. Piece of Injury - At home, term, street, tectory, office building, etc. (Specify) 28t. Location (Street end Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicida Hospital 1 Certifying Physician: To the bast of my knowledge, death occurred et the time, date end plece, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) end menner steted. edical 29a. Cartifier completely (Check only one) the 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 552228 VIPULKUMAR) 30. Neme end addrass of person who complated cause of deeth (Itam 23a) (Type, Print)

BALTIMORE, NID 21214

E. NORTHERN PKWY

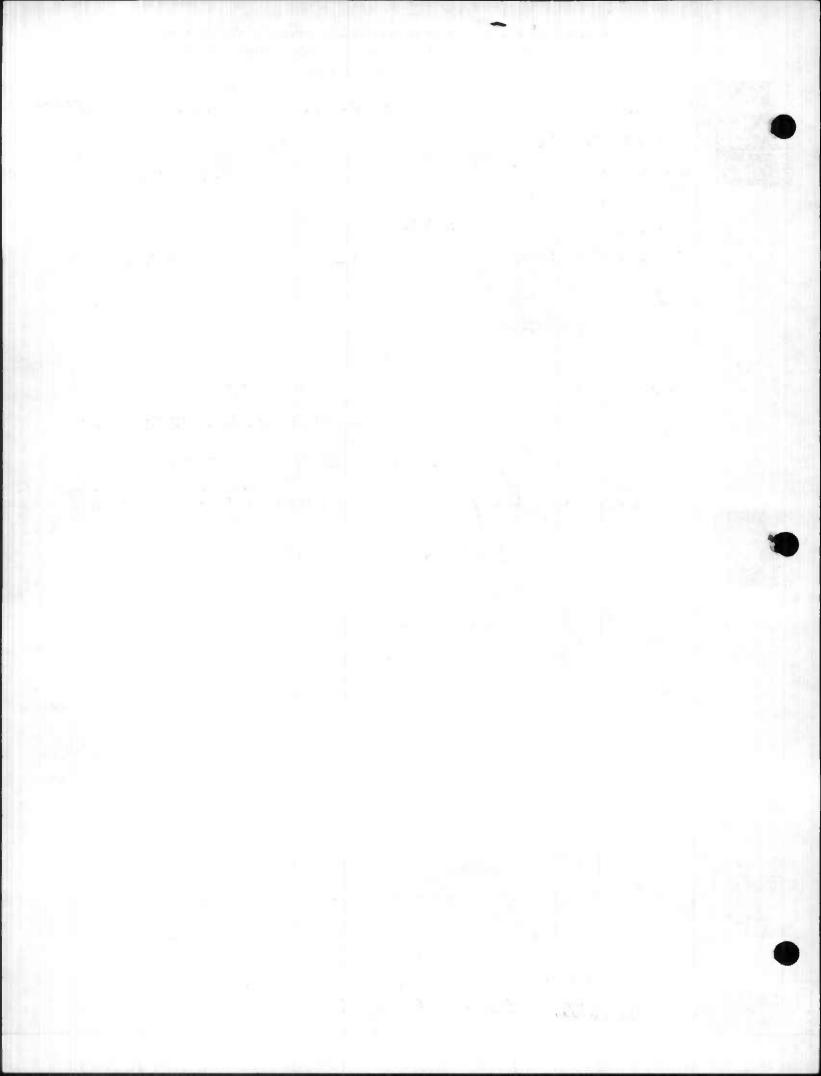
31. Dete fited (Month, Dey, Year) AUG. 0 3 1999

2. Registrer's Signeture

Registrar

DHMH 16 Rev 6/95

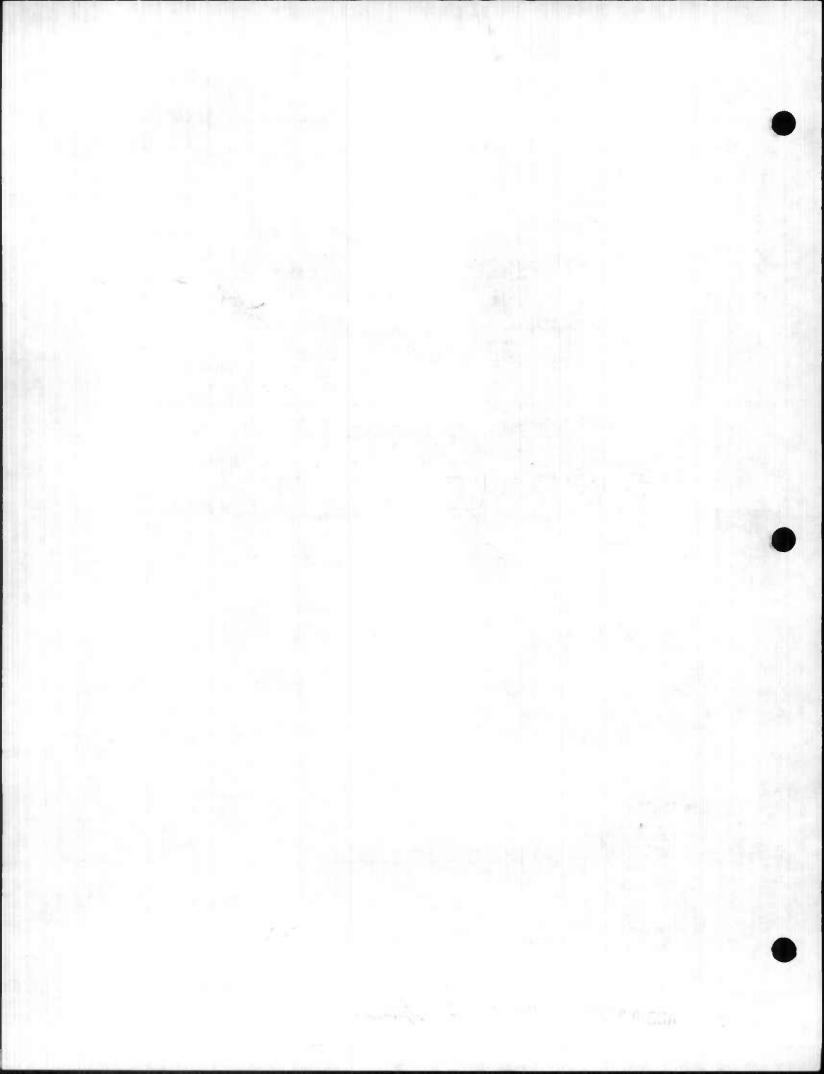
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State of Maryland / Department of Health and Mental Hygiene 9 9 24 22

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/Medical	Marlyn	Lee	Mille	r			July 29	, 1999		6:45am			
Examiner	4e Facility Nema (If not institution, g	nive street and number)			4	lb. City, Town, or	Location of Deeth	4c. County	of Death				
	5 Hillbrook Co	ourt, apt.	104			Timoni	um	Ba1	timor	e			
Funeral		Sex 7. Age	e (In yrs. last bir	thday) If Und Month	der 1 Year	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Dey	Veerl	9. Birthpla	nce (Stete or Foreign			
Director	213-32-7311 Usuel Residence of Decedent	1□ M 2\(\frac{1}{2}\)F	64	Yrs.	s Days	Hours Min.		1935		1and			
or 28a-f show be notified at Director	10a. Stata 10b. County		10c. City, Tow						100	d. Inside City Limits 1 ☐ Yes 2 ☑ No			
or 28a-f a be notified	Maryland Baltimo	ore	T	imonium									
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na 23a matta	5 Hillbrook Court					.093		-	SA				
- 1 mm 1 mm		12. Wes Decedent I Armed Forces?  1 Yes 2 1 N If Yes, Give Yeer or Detes:			cedent of Hoecify Cube	lispanic Origin? (S an, Mexican, Puer Specify:	pecify Yes or No- to Rican, etc.)		- American k, White, at Whit	lc.			
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altimore mit. Pages 1: partment of He portent; if ter y Injury or oth	20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3	Domewal loom State	20b. Plece of cemeter	f Disposition (N ry, cremetory or	leme of r other pled	xe)	Date	20c. Location -	City or Tow	n, Stata			
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W FOR FR	Lemmon Funeral Home												
	Bryan W. Cla			10 W.	Pado	nia Road	, Timoni	um, MD	2109				
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68760, ifficate be executed 9 physician and as the bunal-transit fedical Examiner	Sequentially list conditions.	b	Due to (or as a	consequence of	f):								
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The law requirements have been signed as should Completed							24a. Was e perfor	med?	avail	a autopsy findings			
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The law ate has b page 2 s				,			1 D Y	s 2K) No	10	Yes 2X No			
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Of Vital Physician: The Physician: This certificate rail director, page Ct. To Be Ct.	axaminer? 1 ☐ Yes 2 ☒ No	26. Place of Death (Check only ona)  Hospitel: 1   Inpetient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Rasidence 6   Other (Specify)											
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Division  To the Hospital or Attending F within 24 hours after death.  To the Funeral Director: After completely filled in by the funer  Medical Certification:		Physician: To the best of aminer: On the basis of and manner sta	axamination an										
To the To the Comple	29b. Signature and title of certifier	0		2	29c. Licens	e number	2	9d. Deta signed	(Month, D	lay, Year)			
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	Brian Bohner, M			St., s	uite	407, Bal	timore,	MD 212	04				
State	31. Data filed (Month, Day, Year)	32. Registra	r's Signature	down &									
Registrar	ALIC A SE 1999	-	100	COU CHE SE	1								



## Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death AMEND#2 PER F.H. G774 8-3-99 J.A. 1. Decedent's Neme (First, Middle, Last) JENNINGS GERALD MOSER, JR. 4b. City, Town, or Location of De 4a Fecility Neme (If not institution, give street end number) BALTIMORE ar If Under 24 Hrs. BALTIMORE CITY 8. Date of Birth 10–18–24 9. Birthplece (Stete or Foreign (Month, Dey, Year) LEVINDALE GERIATRIC CENTER CITY If Under 1 Year 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthdey) 1√ M 2□ F Months Deys Hours Min. Yrs. 74 218-12-7044 181924 MARYLAND Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes **2**(☐ No Maryland Baltimore Baltimore County 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number 21085 USA 2906 Woods End Drive 14. Race - American Indien, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1√ Yes 2 No lfYes, Give Yeer or Detes:WW 11 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Mayor & City Council, Elementery/Secondery (0-12) College (1-4or 5+) Baltimore Radio Dispatcher 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Jennings Gerald Moser, Sr. Ruth Marie Debelius 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Jennifer R. McBride 2906 Woods End Drive Joppa, Maryland 21085 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete XIX Burial 2 Cremation 3 Removel from State Sacred Heart of Jesus Cem. 8-4-99 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Facility 21. Signeture of Funeral Service Licensee Lassahn Funeral Home 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respirelory errest, shock, or heart feilure. List only one cause on each line. Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in deeth) Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Wes en eutopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deeth 28d. Describe how injury occurred Injury at Work? 5 Pending investigation Neturel 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

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Examiner Physician/Medical 2 Completed Be 2 Certification:

**Physician** 

/Medical

**Examiner** 

**Funeral** 

**Director** 

r than "natural", or items 23s or 28s-f ahow the Medical Examinar must be notified at

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filed within 72 hours after

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nd 2 should be filed valid and Mental Hygie 27 is marked other in traumatic event,

permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any Injury or other traum pncs.

**Physician** /Medical

**Examiner** 

altimore, Maryland 21215-0020

Directo

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To the Hospital
within 24 hours a
To the Funeral (

Registrar

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4 Homicide

29a Certifier

29b. Signature and title of cartifier

29c. License number

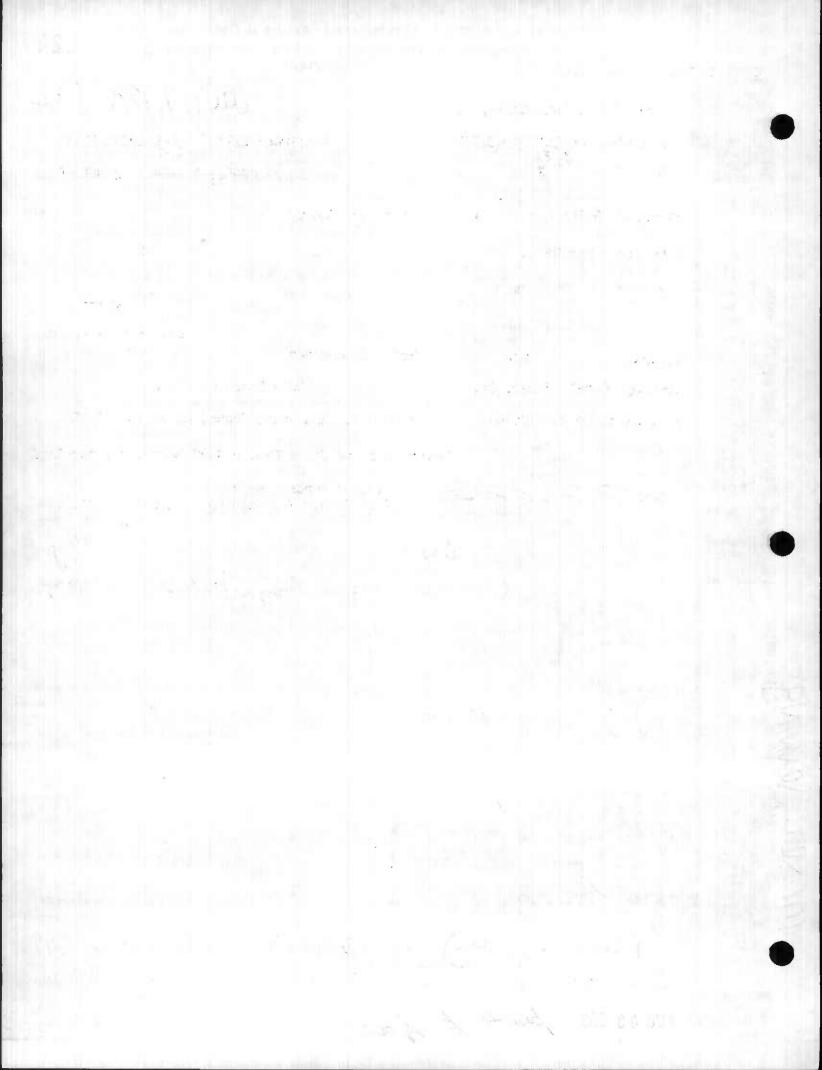
to Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece, end due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end plece, end due to the ceuse(s) end menner stated.

29d. Date signed (Month, Day, Year)

30. Neme end eddress of empleted cause of bea (Item 23e) (Type, Print)

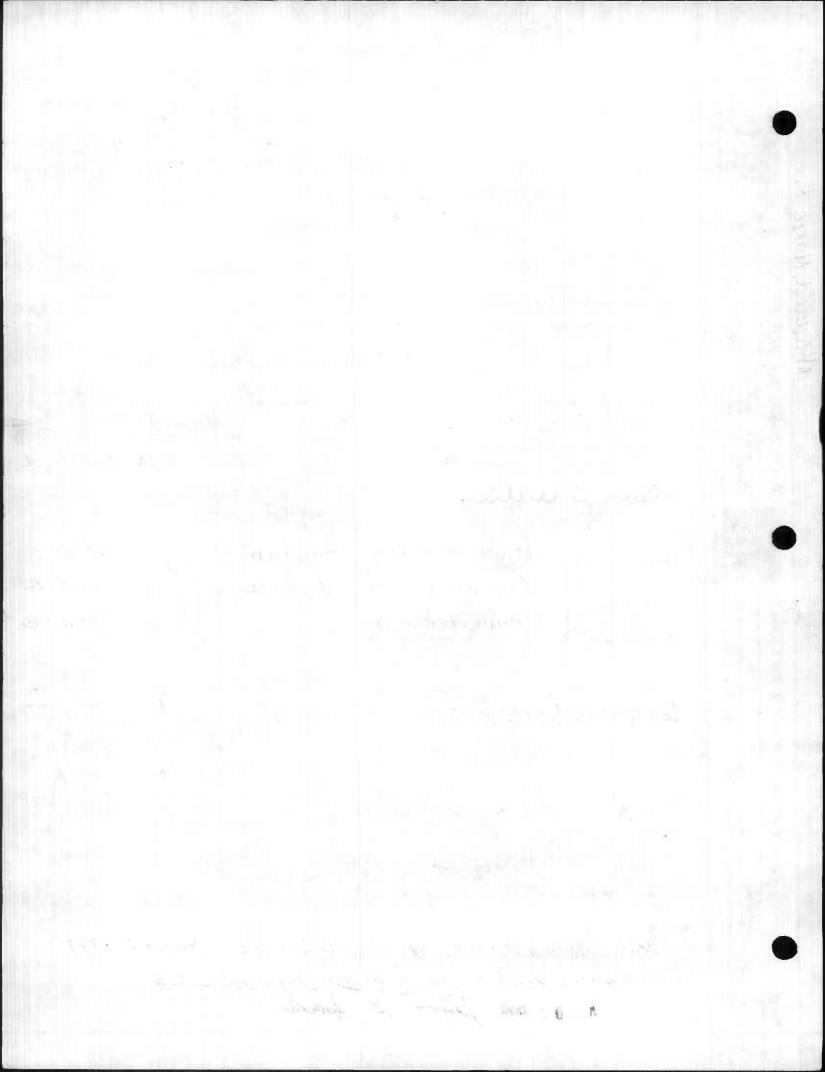
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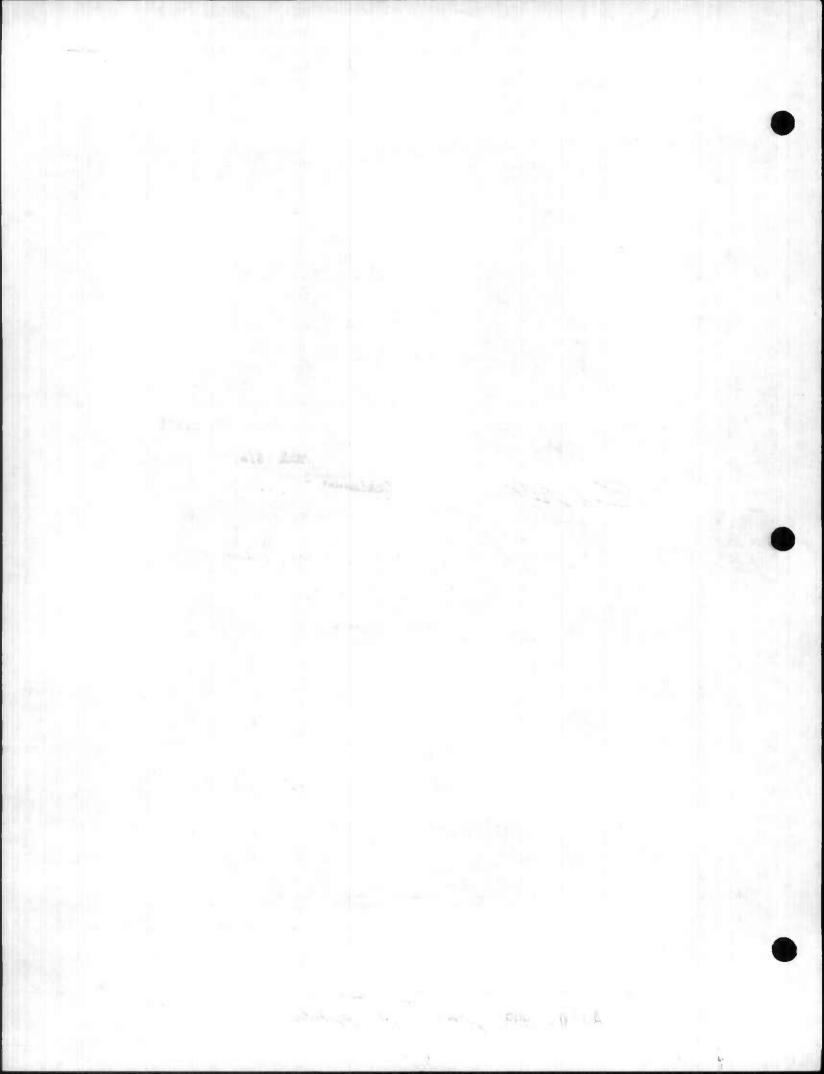
			State	of Maryland		artment rtificate			and N		gieneg g	24	22	25
	61	1. Decedent's Name (First, Midd	le, Last)							2. Date of Dea Month	ith Day	Year	3. Tim	e of Death
3	Physician /Medical		Quaid							July 29 1999 222				.28
	Examiner	4a Facility Name (If not institution					4	b. City, To	wn, or Lo	ocation of Death	4c. County	of Death		
		Fallston Ge		1						ston	Har			
	Funeral Director	5. Social Security Number  216-52-6260  Usual Residence of Decedent	6. Sex 1 □ M 2X F	7. Age (In yrs. les 92	Yrs.	If Under Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Birth  OCC. 8,	1906	9. Birthpl Count	Mari	yland
5-0020 72 hours after deeth with the Manyland	ms 23s or 28s-f show Linust be notified at	10a. State 10b. County		10c. City,		ocation VILLE						10		e City Limits
ar the	or 28e-f a be notified	10e. Street and Number				101. Zip	Code			1	log. Citizen of	What Count	try?	
h will	9 0		Road			211	084				U.S.A			
90	r home 234 siner men	11. Marital Status		cedent Ever in U,S.	13.	_		spanic Ori	gin? (Sp	ecify Yes or No- Rican, etc.)		e - America		3,
UZU ours after	af, or h	3.☐Widowed 4 □ Divorced	ried 1 ☐ Yes	2)[](No		1 Yes 2		Specify:	i, rusito	rucari, etc.)	Specify	ock, White, etc.  White		
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Maryland	Mental arked o artic av	John Privec						Ros	e Di					
Mar 12 sh	la m	19a. Informant's Name/Relations Dennis E. McQu				_				Pal+ima				
- 6	Healt ther	20a. Method of Disposition	1501			_			me,	Baltimo	20c. Location	2123		9
Baltimore	epertment of reportant: If Ik ny Injury or o nce.	1 Burial 2 Cremation 4 Donation 5 Other (S	pecify)	JUNE	Holy	Rede	emer			3/2/99				ryland
BB F	Deper Impor	21. Signature of Funeral Service Licensee  22. Name and Address of Fecility  Schimunek Funeral Home, Inc. 9705 Beld										rin 1	Road	
/ //	nysician Medical kaminer	23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Finel disease or condition resulting in death)		caused the death. each line.  Te myo  Due to (or a	card	lial i	_				rest,	1	Onset a	mele Between and Deeth
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	certificata rector, pag Be Co	25. Was case referred to medica	f					26. Place	of Deat	h (Check only o	ne)			7
Physician:	I direct	1 Ves 2N No	Hospital:	Inpatient 2 EF	VOutpatie	nt 3 DO	A Oth	97: 4 Nu	rsing Ho	me 5 Resid	ence 6 Oth	ner (Specify	y)	- 112-11
	death. ctor: After this y the funeral d fication: To		g (Mo	28a. Date of Injury (Month, Day Year)   28b. Time of Injury   28c. Injury at Work?   M   1   Yes 2   No					No	28d. Describe how injury occurred				
5 8		3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 286, Plac	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number of Rural Ro								Vumber,		
I Hospital	Funer taly fill	29a. Certifier 17 Certifyir (Check only one) 2 Medical	Examiner: On the I	e best of my knowle basis of examination nner stated.	edge, deat n and/or in	h occurred envestigation,	ot the tim	ne, date an pinion, dea	d place, th occur	end due to the d red at the time, d	cause(s) and m date end place,	anner as st and due to	ated.	se(s)
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	10	Muhaul No.  30. Name and address of person		DIANUL / use of death (Item 2)	-	Print)	D	32.	28	8 Ind $2$	August	1,1	999	,
	\	104 Plumtre 31. Date filed (Month, Day, Year)	e Road	Suite Registrary Signatur	110	Bel	Air	Mai	rylo	and 2	1015			
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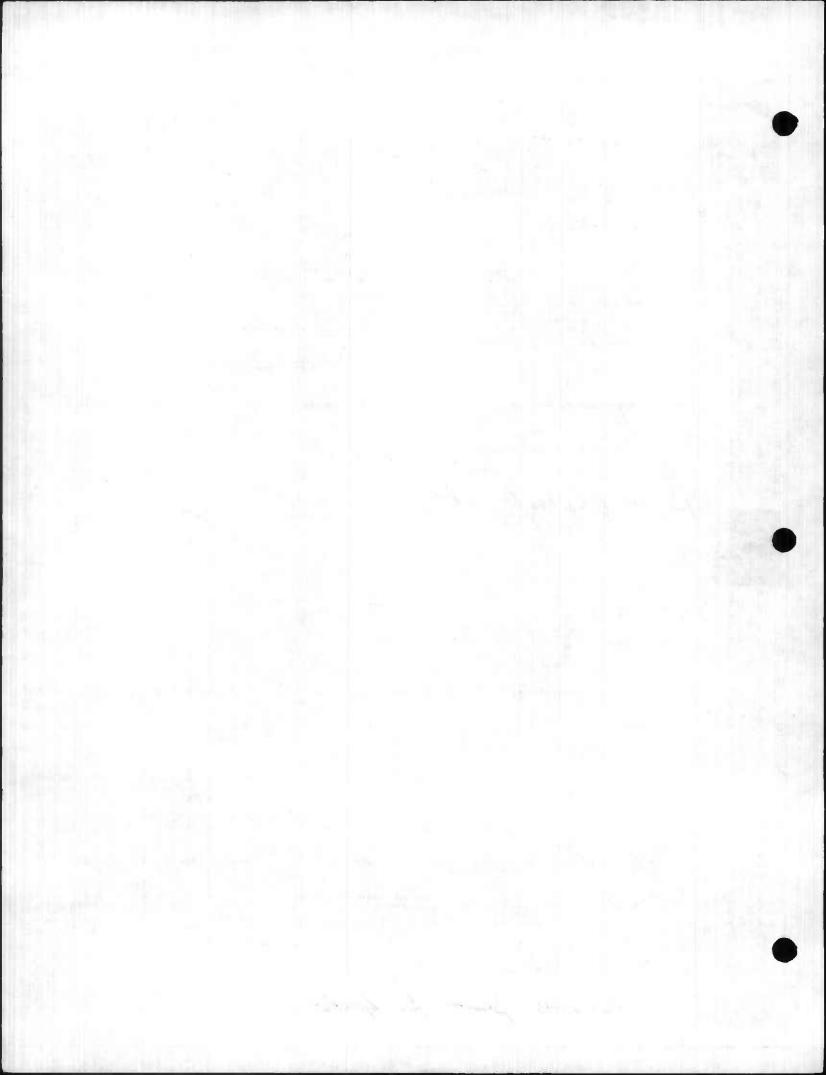
		Certificate of	Death Reg. No.									
	Dia -2-2-	Decedent's Name (First, Middle, Last)	2. Date of Death 3. Time of Death									
	Physician /Medical	Aretta M. Metzgar	August 2 1999 7:01 a.m.									
	Examiner	4a Facility Neme (If not institution, give street and number)	4b. City, Town, or Location of Death 4c. County of Death									
_		Fallston General Hospital	Fallston Harford									
	Funeral Director	5. Sociel Security Number  16. Sex 1 Months  1 M 2 F 80  1 Months	Hours Min. S. Date of Birth (Month, Day, Year) Feb. 28, 1919 Pennsylvania									
	Mand Mand	10e. Stete 10b. County 10c. City, Town or Location	10d. Inside City Limits									
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	fiter death with the Mai r Items 23a or 28a-1a The continue continue Funeral Director	10e. Street and Number 669 Princeton Avenue	18071 10g. Citizen of What Country? U.S.A.									
21215-0020	by	3 ☐ Widowed 4 ☐ Divorced   If Yes, Give   1 ☐ Yes 2 ☐ No	Hispanic Origin? (Specify Yes or No- an, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Bleck, White, etc.  Specify: White									
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	other to vent, the Co		2 Operator Garment Industry  18. Moither's Name (First, Middle, Maiden Sumame)									
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ary	2 should be and Mentalla marked aumatic e		and Number or Rural Route Number, City or Town, Stete, Zip Code)									
	the tra											
ore,		20a. Method of Disposition 20b. Place of Disposition (Name of	ce) Dete 20c. Location - City or Town, State									
E	Pages nent of I int: If Ne ury or or	1 Buriel 2 Cremetion 3 CRemovel from State 4 Donation 5 Other (Specify)  Sky-View Memorial	Park 8/6/99 Hometown, PA									
Baltimore,	Department of Important: If It any Injury or once.	21. Signeture of Funerel Service Licensee 22. Name end Addre	ess of Fecility 2 Funeral Home, Inc.									
_	70 = 4 a	9705 Belo	zir Road, Baltimore, MD 21236									
		23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dyin shock, or heert feilure. List only one cause on each line.	ng, such es cardiác or respiratory errest, Approximate Interval Between Onset and Deeth									
X	Physician / /Medical											
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oʻ	an er inal-t	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  Due to (or as a consequence of):  Due to (or as a consequence of):										
68760,	tificate be executed g physician end as the burial-transit	c. Due to (or as e consequence of):										
	ding p	d										
Box	deeth cert e ettendin ad for use											
0	the d ched	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause give	ven in Pert I. 23b. Did tobacco use contribute to the cause of death?  1 □ Yes 2 □ No 3 □ Probably 4 □ Unknown									
S, D	± 60											
Records,	been sign should be		24a. Wes an eutopsy performed? 24b. Were eutopsy findings available prior to									
ecc	Ple ple		completion of cause of death?									
	The la ate has pege		1 Yes 2 No 1 Yes 2 No									
Vital	certificate rector, peg	25. Was case referred to medical exeminer?	26. Place of Deeth (Check only one)									
of	Z 00 D	1 Ves 2 No Hospitel: 1 Inpatient 2 PER/Outpatient 3 DOA Of	4 Nursing Home 5 Hesidence 6 Hother (Specify)									
UQ.	Affect funer tuner	27. Menner of Deeth 1 Netural 5 Pending 28a. Dete of Injury 28b. Time of Injury Wo										
Sign	Attending or death.  Cotor: After by the fune lification	3 Suicide 6 Could not be	Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number,									
Division	tal or Attending P rs after deeth. al Director: After t led in by the funer Certification:	4 Homicide determined 200. Piece or injury - At nome, farm, street, tectory, office building, etc. (Specify)	City or Town, State)									
	To the Hospital or Attending Ph within 24 hours start death, To the Furneral Director: After th completely filled in by the funeral Medical Certification: 7	29e. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred et the time of the best of examination end/or investigation, in my conditional end menner steted.	ne, date and place, and due to the cause(s) end manner es stated.  pointon, deeth occurred et the time, date end place, and due to the cause(s)									
	within To the compl	29b. Signeture end title of certifier 29c. Licens	se number 29d. Date signed (Month, Day, Year)									
		Vish A Mildows H4	10583 8/2/99									
	a	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	0/-/-									
	1	Stephen Smaldore 2001 Emn	noctors Rd Bel Air MD 21015									
	State	31. Dete liled (Month, Day, Year)  32. Registrar's Signeture										
	Registrar	AUG 0 3 1999 June 3. April	NG/									



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State of Maryland / Department of Health and Mental Hygiene 99 21, 22

				Cei	titica	te of i	Death			Reg. No.					
Dhunisian	1. Decedent's Neme (First, Middle	e, Last)				-			2. Date of De	eath	Veer	3. Time of Death			
Physician /Medical	LINDA	BETH MONE	Υ						July July	30	1999 Year	7:00PM			
Examiner	4a Fecility Name (If not institution	n, give street and nu	mber)			4	4b. City, To	wn, or Lo	cation of Deat	h 4c. 0	County of Death				
	Dulaney Towson	Nursing Ce	nter				Tows	on			Baltimor	e			
Funeral	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under	V 1 Year	If Under Hours	24 Hrs. Min.	8. Date of Bir Month, Di June 1,	rth	9. Birth	nplace (State or Foreign	,		
Director	217-62-7108	1□ M 200 F	46	Yrs.	INIOIRIIS	Duys	Hours	19701.	June 1,	"1953		yland			
than 'netural', or theme 23s or 28s-f show the Medical Examiner must be notified at ompleted by Funeral Director	Usual Residence of Decedent		1.0.00												
28a-f ahow notified at	10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside City Limits			
Ta ob	Maryland Baltim	ore	To	vson			2.					1 ☐ Yes 2 ☐ No			
be nottries Director	10e. Street and Number					p Code				10g. Citize	en of What Cou	intry?			
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	111 West Road				2120	04				USA					
most must be notified at	11. Marital Status	12. Was Dec	edent Ever in U,	S. 13.	Vas Dece	dent of H	lispanic Ori	igin? (Spe	cify Yes or No Rican, etc.)	- 1	4. Race - Amer Black, White		П		
by Fu	1 Never Married 2 Merr	Armed Formed 1 Tes If Yes, Gi	20 No		Yes		Specify:		trousi, oto.,		Panaika				
l by	3 ☐ Widowed 4XXDivorced	Year or D	ates:			202110	opeony.				Specify:	White			
Completed	15. Deceden (Specify only highe:	t's Education		16a. Deced	lent's Usu	al Occup	ation	at of worki	na	16b. Kin	d of Business/I	ndustry			
npleted	Elementary/Secondary (0-12)	College (	1-4or 5+)				during mos d)								
Co		4		Soc	ial W	orker					State of	Maryland			
Be	17. Father's Name (First, Middle,	Last)					18. Mother's Name (First, Middle			, Maiden S	Sumame)				
0	Lester P Chacey					Char	riotte	Dodson							
5	19a. Informant's Name/Relations	hip (Type, Print)		19b. Meilir	ng Addres	s (Street	and Numbe	er or Aura	l Route Numb	er, City or	Town, State, Z.	ip Code)			
5	Charlotte E Lewis		Mother	730 Ca	mberl	ey Cir	rcle 1	Towson	Marylar	nd 2120	14				
one.  To Be Comp	20a. Method of Disposition	о ПР		tace of Dispo	sition (Na	me of other plac	ce)	1	Date 20		20c. Location - City or Town, State				
2	4 Donation 5 Other (S		Lorraine Park Cemetery					8/	3/99	Balti	Baltimore, Maryland				
r Injury	21 Agriature of Funeral Service	Licensee /	/	22	. Name a	nd Addres	ss of Facilit	ty Mi	toboll L	li odofo	ld Ermon	al Home Inc.			
à da	Dannis OVO	16. 1VO	. ah	65	00 Vo	ok Dos	nd Dall		, Maryla			at nulle tric.			
	23a. Pert1. Enter thé disease, or shock, or heart failure. List	complications that	eused the death								. 14	Approximate	_		
ician	shock, or heart failure. Eist	only one cause on e	each line.									Interval Between Onset and Deeth			
dical	Immediate Cause (Final		dina		C	01	=0-	Cic							
niner	disease or condition resulting in death)  a. NUCTPLE SCLEROSIS											_			
<b>5</b>			Due to (o	r as e conseq	uence of)	:									
the burlatransit		<b>b</b>	Due to fe												
X	Sequentially list conditions, if any, leading to immediate		Due to (or as a consequence of):												
	cause. Enter Underlying Cause (Disease or injury that initiated events	с										_			
Medical	resulting in death) Last		Due to (or es a consequence of):												
		d													
cla cla	Date H. Others I and Harris A. C. Maria					23b. Did tobacco use contribute to the cause of death									
etached for u Physician	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							1.				. /			
4									10	T08 2L	JNo 3∐Ph	obably 4 Unknow	7)		
d by F									242 Was	an autops	24b V	Vere autopsy findings	_		
Pege 2 should										ormed?	a	vailable prior to completion of cause			
mpi											0	f death?			
Con	•								10	Yes 2D	LNO 1	☐ Yes 20 No			
Be C	25. Was case referred to medical examiner?							of Death	(Check only	one)					
P 6	1□ Yes 2D No	Hospitat:	1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ☐ 4 ☐ Aursing Hom						lome 5 Residence 6 Other (Specify)						
funera tlon:	27. Manner of Death 1 D Naturat 5 □ Pendin	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury	1	28c. Injun World	y at k?	2	28d. Describe	how injury	occurred				
I in by the fu ertification	2 ☐ Accident investig	ation	M 1 Yes 2 No					No							
ed in by the funera Certification:	3 Suicide 6 Could r 4 Homicide determ	ned 208. Place	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					2	28f. Location ( City or To		Number or Ru	ral Route Number,			
	building, die. (opwing)														
edical	29a. Certifier 1 Certifyin	g Physician: To the Examiner: On the b	best of my know	wledge, death	occurred	at the tim	ne, date an	d place, e	and due to the	cause(s) a	and menner es	stated.			
pleti.	one)	and man	ner stated.	IN STREET	astigation	-, striy O	рипол, 088	nii occurre	o at trie time,	Date and t	pave, and due	to are cause(s)			
completely filled in t	29b. Signature and title of certifier	meluja	-		29		e number	- 0	/	29d. Date	signed (Month	, Day, Year)			
	1 703 00	1			-	DS	22	20	>	7	1311	99			
0	30. Name and address of person	who completed caus	se of death (Item	23a) (Type.	Print)				0		1				
,	VIPULKUMAR BH	ALODIYA	3007	C. No	RTH	ERN	PKL	· Y .	BACTI	MORC	= MD	21214			
State			egistrar's Signat	-	1	- 11	,	/ /			-	*	0		
State Registrar	31. Date filed (Ment) Gay (Year)	1999	Laco de la constitución de la co	Ø.	popo	acks									



Please Type or Print In Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Physician Patricia A. Mann 23, 11:30 a.m. July 1999 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare Perring Parkway Parkville Baltimore 5. Social Security Number 219-32-5253 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
July 4, 1935 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 X F 64 Yrs. Director Usual Rasidance of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28s-f show N/A 1 X Yas 2 No Baltimore City Md. Director 10e. Street and Number 10f. Zio Code 10g Citizen of What Country? 3015 Harview Avenue 21234 Serve 23a United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, Whita, atc. 12. Was Decedant Ever in U,S Armed Forces? 11. Meritel Stetus 72 hours after 1 ☐ Yas 2 🕱 No If Yas, Giva Yaar or Datas: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 'natural', or 1 Yes 2 No Specify: Specify: White 3 Ø Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry filed within Hygiene. Elamentery/Secondary (0-12) Collega (1-4or 5+) Retail Clerk 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Pages 1 and 2 should be III ment of Health and Mental H tant: If Ifem 27 is marked off Be Unknown Starr Unknown Unknown 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code) Department of Health a Important: If Item 27 is any injury or other traces ance. 3329 Texas Avenue Baltimore, Maryland 21234 Gloria E. Harris 20b. Place of Disposition (Nama of cematery, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 Ø Crametion 3 ☐ Removel from Stata 4 ☐ Donetion 5 ☐ Othar (Specify) Hilltop Service Corp. 7/31/99 Towson Maryland 21. Signature of Funaral Sarvice Licensee Milton 22. Nama and Address of Facility Knight Jr Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214 Approximata Interval Between Onset and Death 23a. Part1. Enter the disaesa, or shock, or heart failura. Lie ath. Do not entar tha mode of dying, such as cardiac or respiratory arrest, **Physician** /Medical Immediata Causa (Finel Si New 14 diseasa or condition rasulting in death) Examiner Due to (or as a consequence of): Examiner physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Diseese or Injury that initiated events rasulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of) 987 signed by the a P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 2/2 No 1 Yes 2 No certificate Division of Vital or Attending Physician: director. Be 25. Was case rafarrad to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral ( 28a. Data of Injury (Month, Day Year) 27. Mennes of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Affer 1. Natural 5 Pending 1 ☐ Yas 2 ☐ No death. 2 Accidant Invastigation 24 hours after deat Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) filled in by 4 Homicida Hospital Dertifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and mannar as stated.

Medicat Exampler: On the basis of axamination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a, Cartifiai (Check only one) within 2 90 29b. Signature and Mile of certi 29c. License number 29d. Data signed (Month, Day, Year) 30. Name and addrass of person who completed causa of death (Item 23a) (Type, Print)

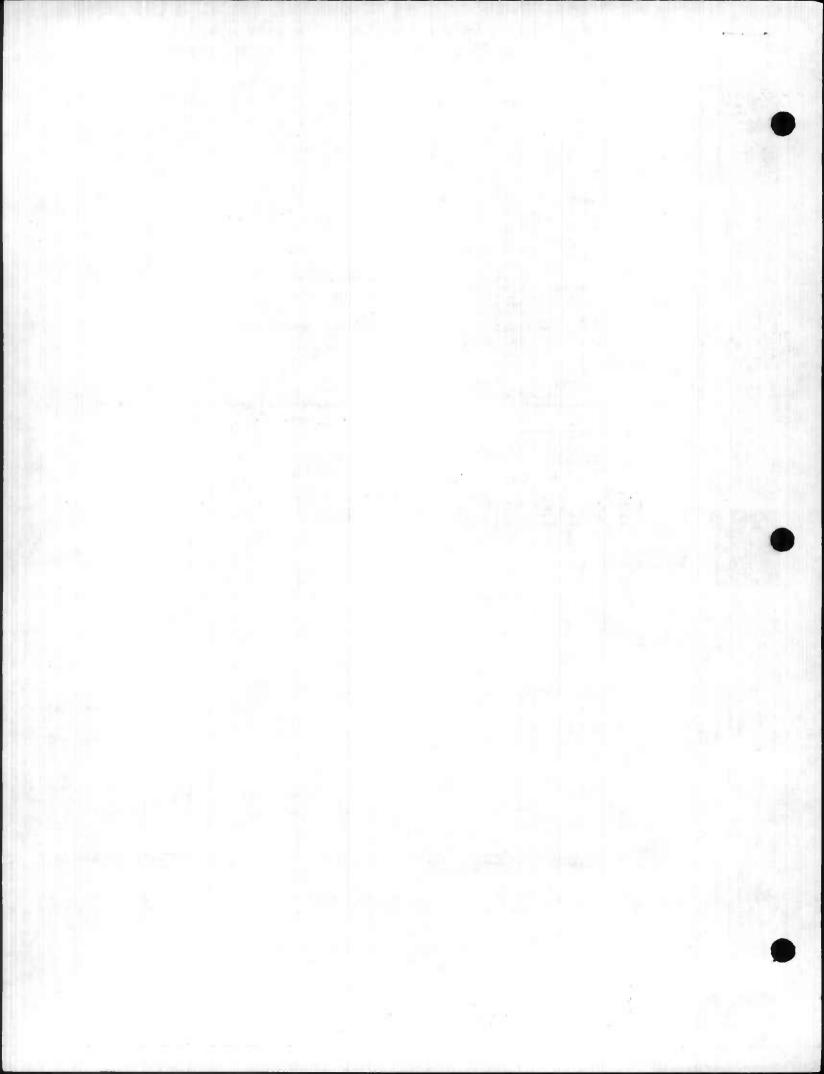
State Registrar

**DHMH 16 Rev 6/95** 

32. Registrar's Signature

31. Data filed (Month, Pay, Year) AUG 0 3 1999

Sports



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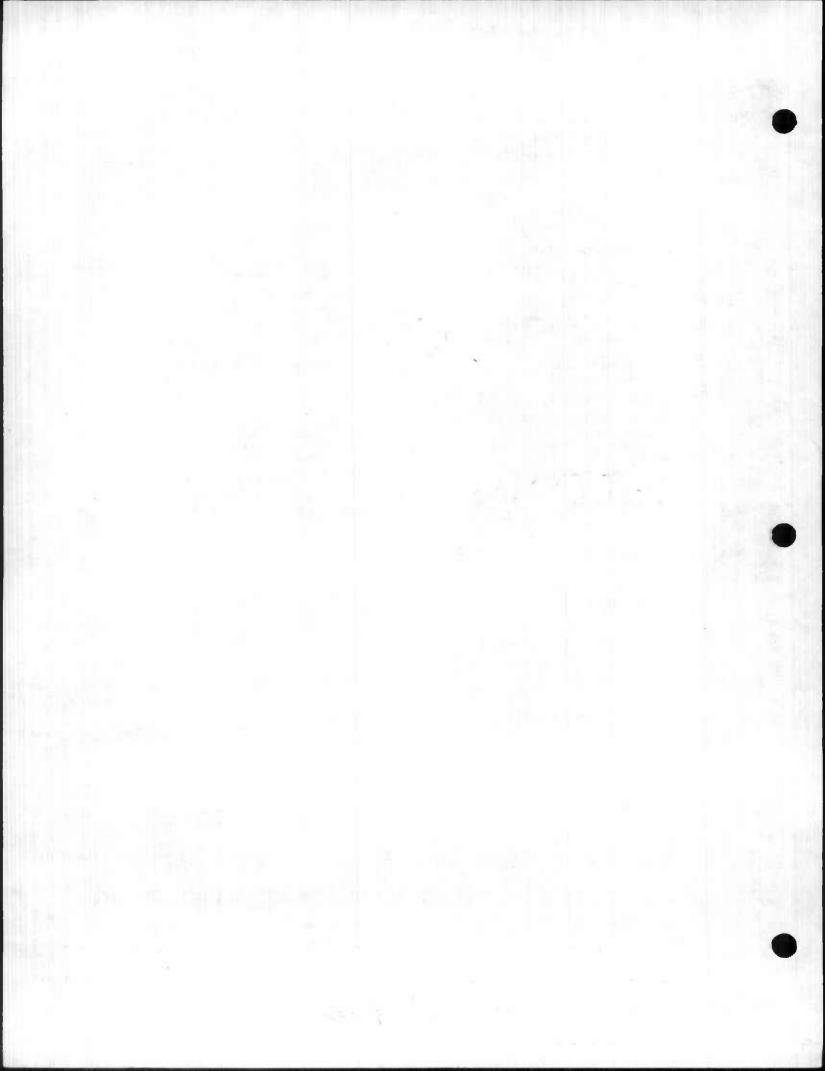
State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** William Edwin Nutwell Sr. 1999 4:38pm August /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Annapolis 307 Edgemere Drive If Under 1 Year If Under 24 Hrs.
Months Devs Hours Min. 8. Date of Birth (Month, Day, Year) Dec. 13, 1911 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Deys Months 1QM 20 F Yrs. 87 Maryland Director 218-36-3060 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "netural", or items 23s or 28s-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 No Annapolis Director MD Anne Arundel 10f. Zip Code 10e. Street and Number 10g, Citizan of What Country? USA 21403 307 Edgemere Drive Funaral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiens. Important: If Itam 27 is marked other than "natural", or than any linux or other traumatic event, the Medical Process 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0020 White 1 ☐ Yes 2 ☐ No Specify: Specify à 3☐Widowed 4☐Divorced Complated 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Farming Farmer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 Julia Adella Alphonso Nutwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) 307 Edgemere Drive, Annapolis, MD 21403 Rosalie Nutwell (Daughter) 20b. Place of Disposition (Nama of 20a. Method of Disposition 20c. Location - City or Town, State atery crematory or other placel 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 08/04 Galesville, MD Woodfield Cemetery 4 Donation 5 Other (Specify) turn of Funeral Service Licen 22. Name and Address of Facility
Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, 21401 MD plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediata Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner The lew requires that the deeth certificate be executed use as the buriel-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequence of): P.O. Box 68760. physician Due to (or as a consequence of) signed by the aid be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably Unknown 1 ☐ Yee 2 ☐ No SMUNDA Division of Vital Records, P 24b. Wera autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? hes paga 2 certificete 1 Yes 1 □ Yes 2 □ No or Attending Physician: funeral director. 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) 1 Yes 2 TVO Other: 4 Nursing Home 5 Masidance 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? Affer 1 EtNatural 5 Pending To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicide TST Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and due to tha cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BUNAPOL HAMILTON, MD 21401 MOHABLE 32 Aegistrar's Signature

**DHMH 16 Rev 6/95** 

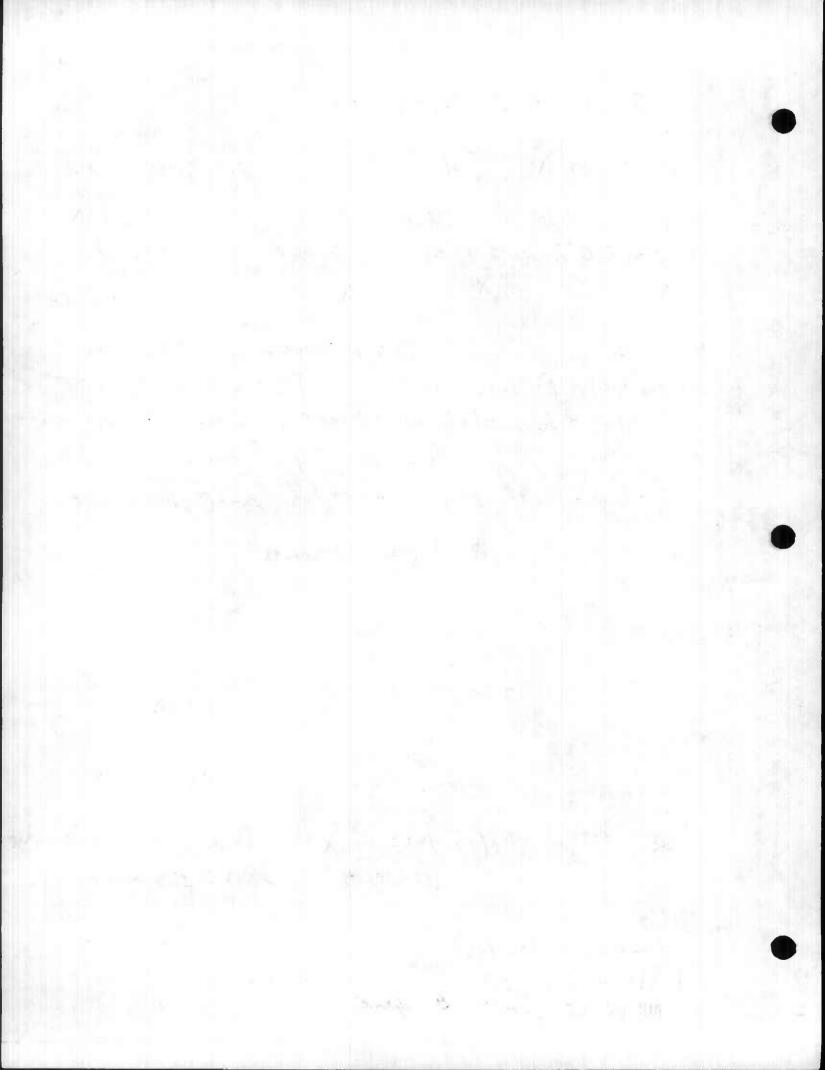
State Registrar

3 1999



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Timothy J. Niziolek Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month July 28, 1999 **Physician** OLE MOI 2:29 PM /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 895 south exit to 95 south Elkridge Howard If Under 24 Hrs. Hours Min. If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country), 6. Sex Funeral Days 1 M 2 F 213-12-1048 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10a. Stete 10b. County 10d. Inside City Limits 28a-f show 1 Yes 2 No Director MORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 NUELL 238 Funeral 12. Wes Decedent Ever in U.S.
Armed Forces?
1 Yes 2 No
If Yes, Give
Yeer or Detes: 11. Meritel Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. al Hygiene. other than "natural", or ite Never Merried 2☐ Merried 1□ Yas 2 No Baltimore, Maryland 21215-0020 Specify. þ Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Coilege (1-4or 5+) DRIVER permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If from 27 is marked othe eny injury or other traumatic event, block. 17. Fathar's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) 0 19e. Informant's Neme/Feletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 2419 VOSE BALTIMERE, MD. 20b. Piece of Disposition (Name of cemetery, cremetory or other) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 F 4 Donation 5 Other (Specify) 3 Removel from Stete ETRO (REMAIOR 22. Neme and Address of Fecility Approximate Interval Between Onset and Death 23a. Part1. Enter the disaese of complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart feilure. List only ona causa on each line. **Physician** Immediete Cause (Final disease or condition resulting in deeth) /Medical Examiner Dua to (or as a consequence of): Physician/Medical Examiner sician and burial-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaese or Injury that initiated events Due to (or es e consequenca of): Box 68760. physician that initiated events resulting in death) Last Due to (or es e consequenca of): P.O. Pert If. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by I 2 XNo 3 Probably 4 Unknown Division of Vital Records, þ 24a. Was an autopsy performed? 24b. Wera autopsy findings Be Completed available prior to completion of cause of death? Yes 2 No 1 Yas 2□ No 25. Was case referred to medical 26. Place of Death (Check only ona) Hospitel: Other: 4 Nursing Home 5 Residence & Othar (Specify) Scene XXXVes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Deeth Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred the Hospital or Attending hin 24 hours after death. After 1 Neturel 5 Pending investigation Uriver in notor ve 22 2 No the occide Accidant Director: 6 Could not be determined 281. Location (Street end Number or Rural Route Number City or Town, stete) 3 ☐ Suicide Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide + DOHUM 95 To the Hospital or within 24 hours str To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledga, death occurred at the time, date end place, and due to the course(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. 29b. Sigr e and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) O.C.M.E. July 29, 1999 pleted causa of daath (Item 23a) (Type, Print) VOCK 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State AUG 03 Registrar

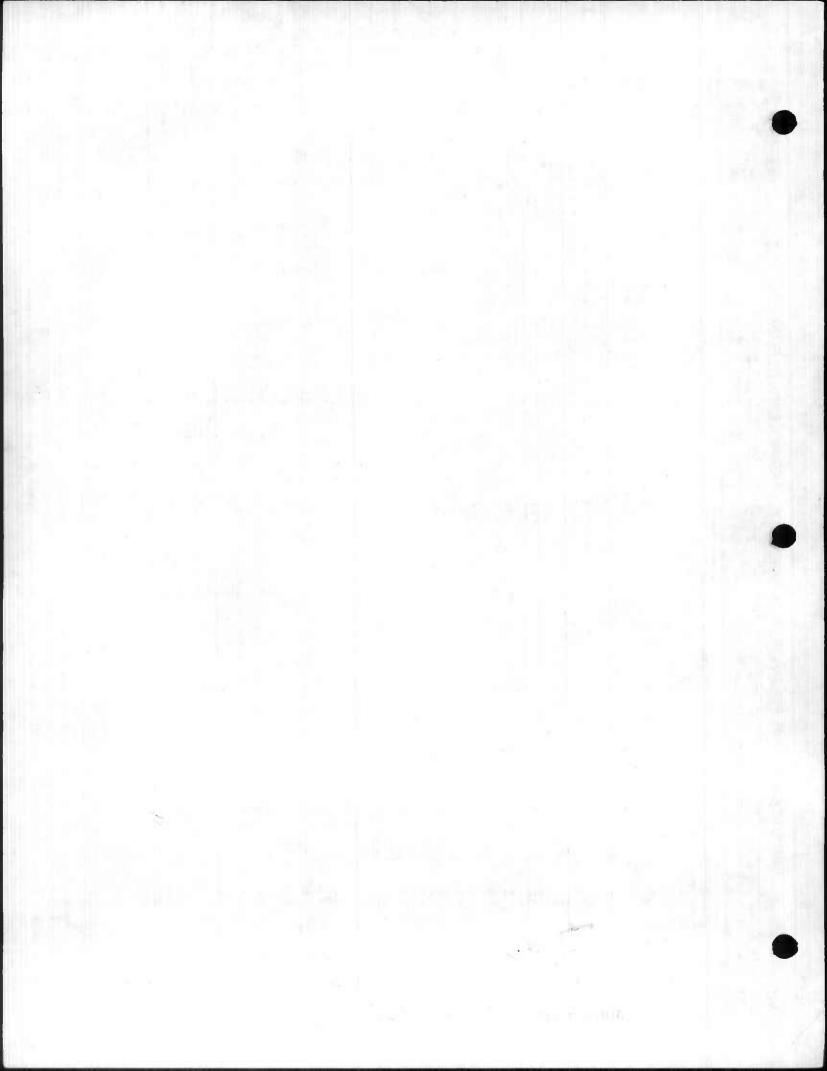


# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 09:15pm Physician July 31 Neville Faru /Medical 4a Facility Name (If not instrution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Geriatric Bultimore Baltimore City Hookins # Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days 1**X** M 2□ F 62 Director 218-32-6983 PA 25 Nov 1936 **Usual Residence of Decedent** 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yas 2 ☑ No Director MD Baltimore Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7007 Baltimore St 21224 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. filled within 72 hours effer Hyglene. Wher than "natural", or its 1 Never Married 2 ☐ Married 1 ☐ Yes 21 No If Yes, Give Year or Dates: Baitlmore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: è White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) parmit. Pages 1 and 2 should be filed will Department of Heelth and Mental Hyglen. Important: if item 27 is marked other than eny injury or other traumatic event. Imp. page. 6 Never Worked None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 80 Frank L Neville Sr. Mabel Abbott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Frank Neville Jr /brother 7424 Poplar Ave Baltimore, MD 21224 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State Aug 2 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 1999 Catonsville, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Connelly Funeral Home of Dundalk 7110 Sollers Point Rd onn 21222 23a. Part1. Enter the disease, or complications that caused the death shock, or heart lailure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) One month Examiner Due to (or es a consequence of): Examine physician and a the burial-transit The law requires that the death certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. signed by to 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? Completed peeu dron 1 Yes 2 No this certificate hronic 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1□ Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attanding Phy within 24 hours effer death. To the Funeral Director: After thi completely filled in by the funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? Medical Certification: 1 K Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, Ierm, street, lectory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier rou 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore 4940 tastern -ne 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

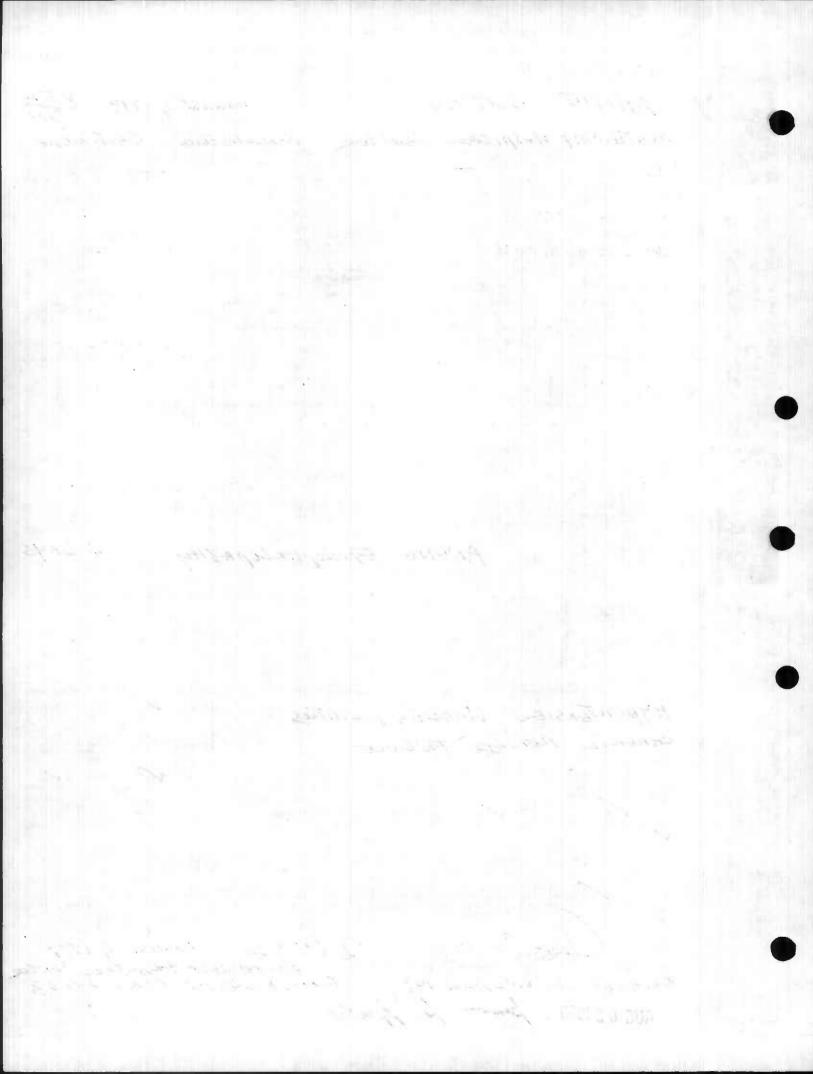
AUG 0 3 1999



State of Maryland / Department of Health and Mental Hygiene 99

Certificate of Death AMEND #7&8 PEE F.H. G774 8-3-99 J.A. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death ANNIE 852 **Physician** AUGUST 1 OUTING /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NONTHWEST HOSPITAL CON TOR RANDAUS ZOWN BALLI MORE 8. Date of Birth (Month, Day, Yea Dec. 10, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 6. Sex Year) 1940 9. Birthplace (State or Foreign Country) 0, 1946 Virginia **Funeral** Days Hours 1□M 20 F Virginia 219-38-0798 **59** 58 **Director** Usual Residence of Decedent 10a. Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Baltimore Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 2410 Bibury Lane, #104 21244 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2XXVo If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☐ Married Specify: African yland 21215-0020 1 ☐ Yes 2 ☐ No Specify: P 3 ☐ Widowed 4 Divorced American Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be lited within. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "I say Injury or other traumetic event, the Med College (1-4or 5+) Elementary/Secondary (0-12) Nursing/Highland 12 Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maggie Bailey Eddie Tankard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) 108 Lahinch Drive, Millersville, MD Thomas J. Outing, Sr., Son altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MD 8/5/99 4 ☐ Donation \_5 ☐ Other (Specify) Loudon Park Cemetery 21. Signature of Funeral Service Licenses 22. Neme and Address of Facility Loudon Park Funeral Home, 3620 Wilkens Avenue Baltimore, Maryland 21229 23a, Fart / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or hear failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) ENCEPHALOPATHY **Examiner** Due to (or es a consequence of) The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): 5x 68760 Physician/Medical Due to (or as a consequence of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? DIABETIS Mollitus 1 Yes 2 Ho 3 Probably 4 Unknown Records, Be Completed by ata has been signe page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 200 No 1 Yes 2 No of Vital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 22 No Medical Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division After 5 Pending investigation 1 Natural after deeth. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 24 hours a Hospital Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 \$ 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of partition AUBUST 1, 189 12502 NONTHWEST HOSPITAL BONZ NANDAHISTONNE MIN. 20133 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B. Cowaran ONCANIDO 31. Date filed (Month, Day, Year) #2. Registrar's Signature State AUG 0 3 1999 pour Registrar

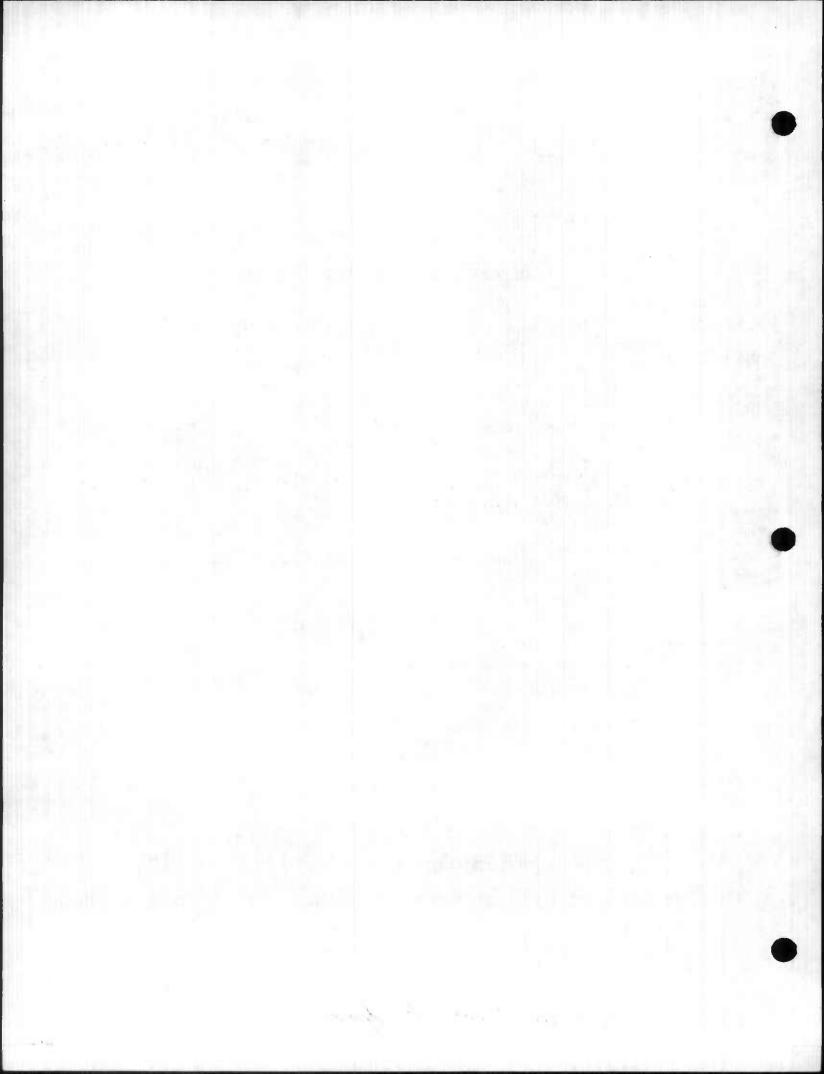


99-4523-510 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. jhm State of Maryland / Department of Health and Mental Hygiene ARLENE Certificate of Death Reg. No. OGDEN 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Dey Month Yea **Physician** Arlene Ogden AUGUST 02, 1999 01:45 AM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner JOHN HOPKINS BAYVIEW BALTIMORE Baltimore City If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 M 20 F Director Oct 8, RI 039-07-4280 1921 Usual Residence of Decede the Maryland 10a. Stete 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 1846 Marshall Rd 21222 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Rece - American Indian. 11. Merital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Introdumt: if Nem 27 is marked other than "natural", or item any injury or other treumatic event, tre Health and pages. Black, White, etc. 1 ☐ Yes 2 ☐XNo 1 Never Married 2X Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White by 3 Widowed 4 Divorced Year or Detes Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Housewife Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Charles A. Hayhurst Ethel Holroyd 19a. Intorment's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Willard Ogden /husband 1846 Marshall Rd Baltimore, MD 21222 20b. Plece of Disposition (Name of cemetery, cremetory or other ptece) 20a. Method of Disposition Dete 20c. Location - City or Town, Steta 1 Buriel 2 □ Cremetion 3 □ Removal from State Aug 4 4 Donation 5 Other (Specify) 1999 Gardens of Faith Baltimore, MD 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility
Connelly Funeral Home of Dundalk Sollers Point Rd 7110 23e. Part1. Enter the disease, or complications thet caused the shock, or heer tailure. List only one ceuse on each line. Approximate Intervel Between Onset and Death h. Do not enter the mode of dying, such as cardiac or respiratory errest, **Physician** /Medical Immediate Cause (Final · Athroschrotic Cardiovascular Disease diseese or condition resulting in deeth) Examiner Due to (or as a consequence of) Examiner ician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Box 68760. physician Physician/Medical eu Due to (or as a consequence of): 88 980 P.O. Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2⊠No 3 Probably 4 Unknown signed i Records. Š 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 s Inspection certificate has 1 ☐ Yes 1 ☐ Yes 2 ☐ No Division of Vital or Attanding Physician: director, Be 25. Was case reterred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 □XER/Outpatient 3□ DOA 1 Inpatient After this 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Netural 2 Accident 5 Pending 1 Yes 2 No death. investigation 24 hours after deat Funeral Director: 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, term, street, tectory, office building, etc. (Specify) 28t. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 D Homicide filled in Hospital 29e. Certifler Medical 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and menner as stated. completely (Check only one) 2 A Medical Examinar: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete and piece, and due to the cause(s) and manner stated. within 2 \$ 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified OCME AUGUST 02, 1999 ND 30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print) Stephen S,
31. Date thed (Month, Day, Year) 111 Penn Street, Baltimore, Maryland 21201 Radentz 32. Registrer's Signeture State

DHMH 16 Ray 6/95

Registrar

AUG 0 3 1999



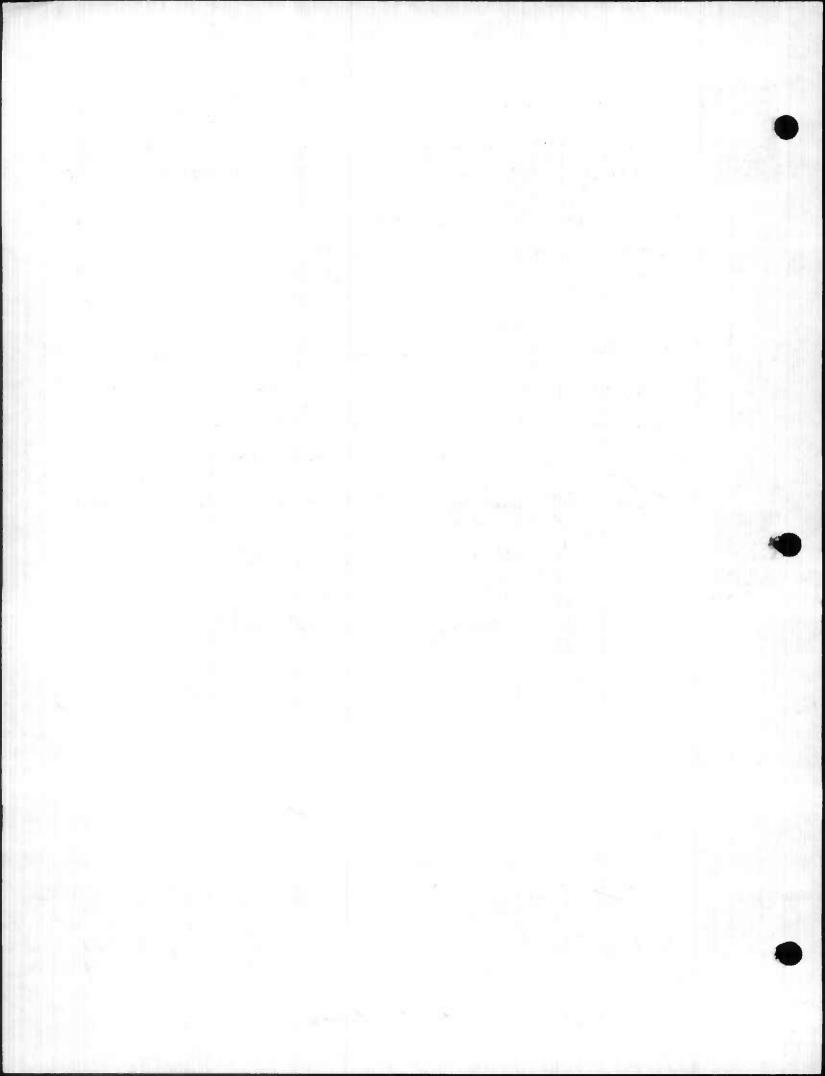
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Deeth 3. Time of Deeth **Physician** Month Corinne Peters July 25, 99 8:55pm /Medical 4a. Fecility Neme (If not institution, give streat and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Sandtown Nursing & Rehab.Center Baltimore If Under 1 Yaar 5. Social Security Number 8. Dete of Birth (Month, Dey, Year)
12-04-05 If Undar 24 Hrs. 7. Age (In yrs. last birthdey) Birthplece (Stata or Foreign Country) **Funeral** Deys Hours Min. 1 M 2 XF Director 101-18-2324 93 Yrs. SC Usuel Residence of Decedent the Meryland 10c. City, Town or Location 10e Stete 10h County 10d. Insida City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Yes 2 No Director MD NA Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? filed within 72 hours efter death with 1000 N. Gilmore Street 21217 USA Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 🕱 No Wes Decedant of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Maxican, Puerto Rican, etc.) 14. Rece - Amarican Indian, Bleck, White, atc. 1 ☐ Never Merried 2 ☐ Married 21215-0020 1 Yes 2 No Specify: If Yes, Give Yaer or Dates: Completed by Specify: Black 3 Widowed 4 □ Divorced 15. Decadent's Education 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) alth and Mental Hygiene. 27 Is marked other than "r r traumetic event, the Med Elementery/Secondary (0-12) 9th Grade College (1-4or 5+) Seamstress Company Baltimore, Maryland 17. Fether's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Meiden Sumema) . Peges 1 and 2 should be file timent of Health and Mental Hy tant: If Item 27 Is marked oth Jury or other traumatic even Be White Jake Martha Unknown 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 912 Wicklow Road Baltimore, Maryland 21229 Charlotte Elliott 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20a, Method of Disposition > Burial 2 □ Cremetion 3 □ Removel from Stete permit. Pege Department of Important: If any Injury or Woodlawn Cemetery 07-28-99 Woodlawn, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Juntal Service Licensae 22. Name end Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue les 23e Pert1. Enter the disees shock, or heart feiture. not enter tha mode of dying, such as cardiac or raspiratory arrast, Approximete Intervel Between Onsat and Death **Physician** /Medical Immediate Cause (Finet disaasa or condition resulting in daath) Examiner Examiner buriel-transit The law requires that the death certificete be executed Sequentially tist conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest pug Box 68760. Physician/Medical the use es P.O. Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 2 Unknown ate has been signed pege 2 should be det Records, þ 24b. Were eutopsy findings evaileble prior to Completed 24a. Wes en eutopsy completion of cause of death? certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physicien: director. Be 25. Was casa referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No Certification: To this funerai Dete of Injury (Month, Dey Yeer) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Affer 5 Pending investigation Neturel 1 ☐ Yes 2 ☐ No within 24 hours efter death. To the Funeral Director: A 2 Accident filled in by the 3 ☐ Suicide 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital \*\*Cortifying Phyaician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner as stated.

2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, dete end pleca, end due to the cause(s) end menner steted. Medical 29a. Certifier completely (Check only one) the 29b. Signatura and title of certifier 29d. Data signed (Month, Day, Year) 29c. Licansa numbar 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

A - A + I M E D M D & 2 I N · Eulaw STruel-Baltimore MD 21201 31. Dete filed (Month, Dey, Year) 32. Registrer's Signature State Registrar AUG 03 1999

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Emma Poole 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deal Urmre Nursene reme If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Months Days Hours Min. 1□M 2ØF Yrs. 217-18-6355 8/29/18 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD N/A Baltimore 1)☐ Yes 2☐ No 10g. Citizen of What Country? 10a, Street and Number 10f. Zip Coda 2527 Popes Lane 21219 USA 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 11. Meritel Stelus Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Naver Married 2 N Married Specify: Black 1 ☐ Yes 2 ☒ No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cook Restaurant Worker 6th 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) James Lewis Annie Gill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Poole 2527 Popes Lane, Baltimore, MD 21219 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c, Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore Cemetery 7/21/99 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22, Name and Address of Facility Betts Funeral Home marles 1129 N. Caroline St., Baltimore, MD 21213 1129 N. Laroline St., Baltimore, Mi pliballe is that ceused the death. Do not enter tha moda of dying, such as cerdiac or respiratory arrest, one cause on each line. Approximate tntervat Batween Onset and Death Bronchisgenic Carcinome Immediate Cause (Final disease or condition resulting in death) Dua to (or as a consequence of): Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Dua to (or as a consequence of). Due to (or as a consequence of) Part It. Other eignificant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Knknown OV 24b. Were autopsy tindings available prior to completion of ceuse ot death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 TYAS 2 No 25. Was cesa raferred to medicel 26. Place of Death (Check only one) axaminer? Hospital: 1 Inpatiant Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death . Date of tnjury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending Investigation 1. Natural Injury 2 No 1 Yes 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicida

The law requires that the death certificate be executed physician and s the burial-trans P.O. Box 68760. attending pl signed by the aid be detached for Division of Vital Records, page 2 certificate Hospital or Attanding Physicien: 24 hours after death. Funeral Director: After this certifica director. funeral filled in by 24 hours a

Physician/Medical þ Completed Be 2 Certification:

**Physician** 

/Medical

Examiner

吉

Funeral

p

Completed

Be

2

Examiner

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nant of Health and Mental Hygiene.

altimore, Maryland 21215-0020

7 is marked other than "naturel", or items 23s or 28s-1 show traumstic event, the Medical Examiner must be notified as

item 27 to other tra

permit. Pages 1 Department of H Important: If ite any Injury or ot

**Physician** 

/Medical

Examiner

State Registrar

Medical

29a. Certifian

(Check only one)

30. Name and Adv

29b. Signeture end title

31. Date filed (Month, Day, Year) AUG 03

pleted causa of death (fram 23a) (Type, Print) Pinan

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12 Certifying Phyelcian: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and mainner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Tree Rd

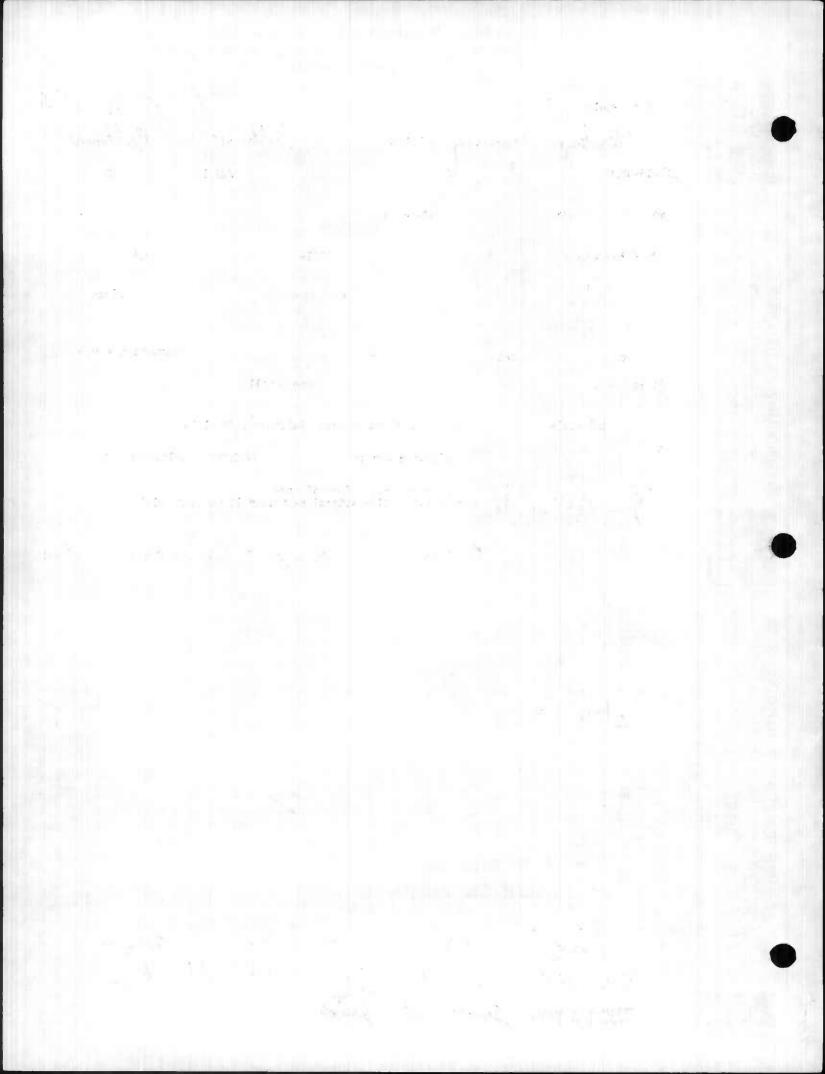
32. Ragistrar's Signatura

**DHMH 16 Rev 6/95** 

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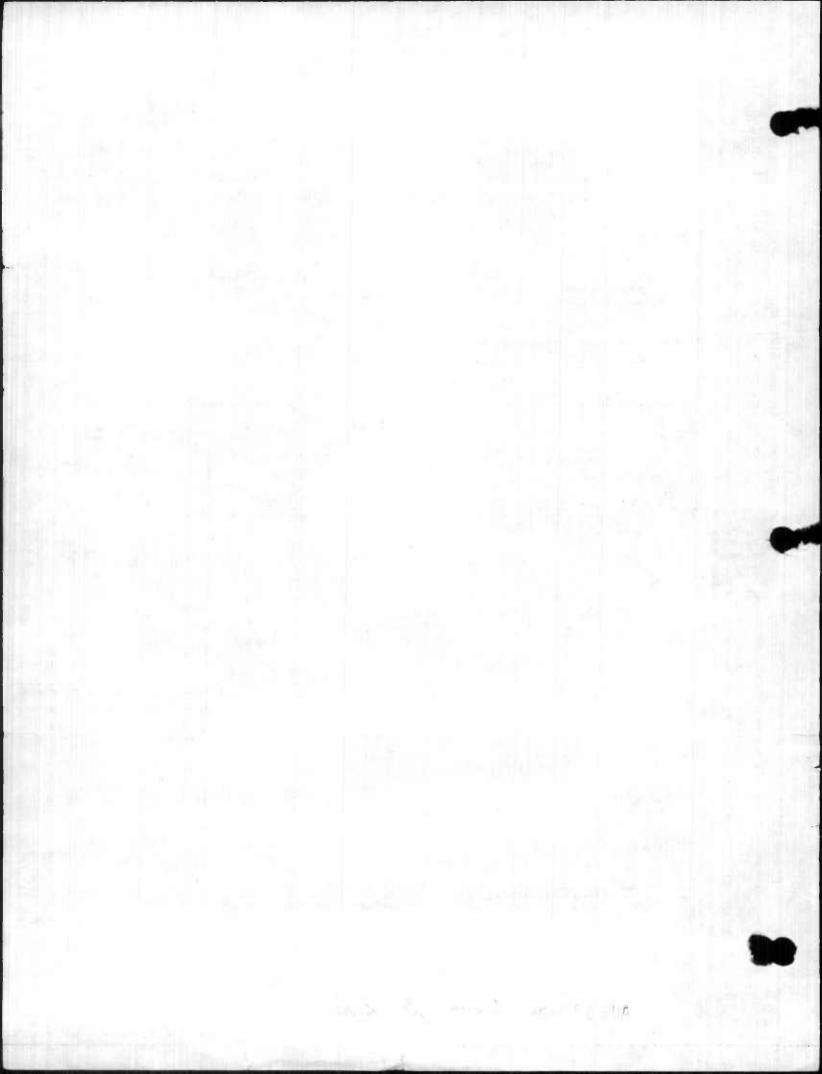


# Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Date of Death Physician Month Shirley Pribila August 01 1999 10:45 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2916 Golden Fleece Drive Pasadena Anne Arundel Co. 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min 1□M 20 F 50 212-48-0260 Director Aug. 03 1948 West Virginia Usual Rasidance of Decedant with the Maryland 10b. Count 10c. City, Town or Location 10d. Inside City Limits show 1□ Yes 25 No Md. Director Anne Arundel Co. Pasadena 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Itama 23a or 2916 Golden Fleece Drive 21122 Funeral USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nert of Health and Mental Hygiene.

Intel if Nem 27 is marked other than "natural", or its any or other traumatic event, the Medical Example. 1 Yas 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify py Specify: 3 ☐ Widowed 4 ☒ Divorced white Completed 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Barber self-employed n/a 17. Fathar's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Be Robert Lee Holleman Hazel Lucas 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 2916 Golden Fleece Drive, Pasadena, Md. 21122
Disposition (Name of Data 20c. Location - City or Town, State Ronald Holleman (Brother) 20a. Mathod of Disposition 20b. Place of Disposition (Name of cematary, crematory or other place) 1X Burial 2 ☐ Cramation 3 ☐ Removal from State Department of Important: If any injury or Glen Haven Memorial Park 8/4/99 Glen Burnie, Md. 4 □ Donation 5 □ Othar (Specify) 21. Signature of Funaral Sarvice Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Md. 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each me. Approximata Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Cancer rear Cell Examine Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiata cause. Entar Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical the Due to (or as a consequence of): 080 Part II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? P.0. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed' certificate 1 Yes 25 No 1 ☐ Yes 2 No or Attanding Physician: funeral director, 25. Was casa referred to medical axaminar? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4□ Nursing Home 5 🕅 Residence 6 □Other (Specify) Medicai Certification: To 1 Yas 2 No this 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 Panding invastigation 1 D Natural after death. 1 TYes 2 No 2 Accident 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicida 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) filled in by 4 ☐ Homicida o the Hospital of within 24 hours at Lethe Funeral D 108 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier completely (Check only one) 29b. Signatura and title of certifier 29d. Data signed (Month, Day, Year) 29c. License number 00054145 Ella Euron MD August 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) 21287 Ella Euron MO 600 N. WOLFE St. MD Baltimore 31. Data filed (Month, Day, Year) AUG 0 3 1999 32. Degistrar's Signature State Registrar

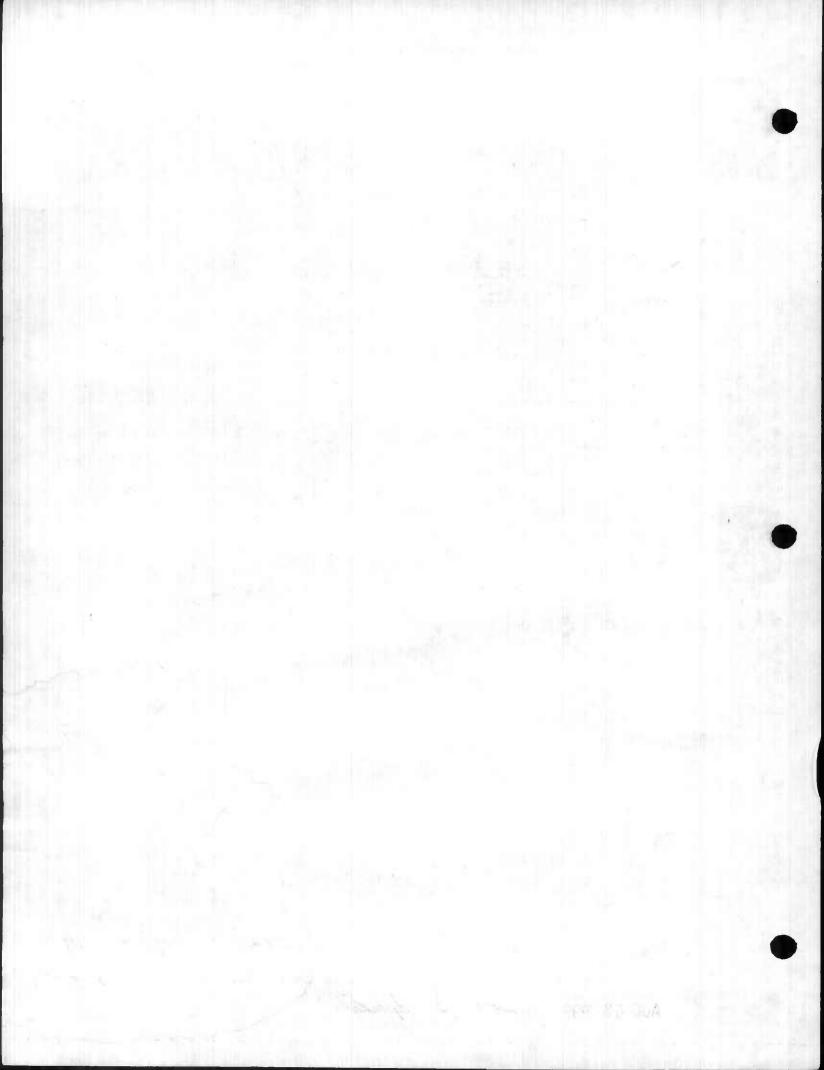
DHMH 16 Rev 6/95



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No. 9 Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Dete of Death Month **Physician** Prince 11 9:15 A.M. Aug. 1999 Betty /Medical 4e Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 602 Laurel Drive Anne Arundel Pasadena If Under 24 Hrs. B. Dete of Birth (Month, Day, Year) OCt. 27, 1933 If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country)
 Maryland 7. Age (In yrs. last birthday) **Funeral** Months Days 1□ M 200 F Yrs. 220-03-9529 Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location ahow 10b. County 10d. Inside City Limits "natural", or items 23s or 28s-f show 1 Yes 2 M No Director Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 602 Laurel Drive 21122 U.S.A. Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 11. Merital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygians... Important: if Itam 27 is marked other than "natural", or item eny injury or other traumatic avent, to Medical Eseminations. Black, White, etc. 1 ☐ Never Merried 2 ☐ Merried 1 Yes 2 No altimore, Maryland 21215-0020 1 Yes 2 No Specify: If Yes, Give Year or Dates: Specify: by 3 N Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 N/A Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) 8 Franklin Thomas Thelma 2 D. M. Brander 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald R. Beall (SON) 602 Laurel Drive Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Dete 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremetion 3 □ Removel from State 8/4/99 4 Donation 5 Other (Specify) Glen Haven Memorial Pk. Glen Burnie, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart leilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Ray Examiner Due to (or as a consequence of) Examiner ective Attanding Physician: The law requires that the death certificate be executed Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician s the burla COVMANY Box 68760. Physician/Medical as e consequence of) Due to (o) P.O. 1 Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dtd tobacco use contribute to the cause of death? signed by the 1 ☐ Yes 2 No 3 Probably 4 Unknown Records, à 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? 2 No 20 No 1 Yes Division of Vital director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 1 □ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this is 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. tnjury at Work? After 1 Natural 2 Accident 5 Pending ne Hospital or Attending n 24 hours after death. The Funeral Director: Aft plately filled in by the fur 1 Yes 2 No investigation 3 ☐ Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, larm, street, fectory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) To the To The To the F 29d. Dete signed (Month, Day, Year) 29b. Signature and fitte of certifler 29c. License number 019512 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Surk 206 Gen Burns S.H. M.D SANG C 1600 Cram 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 03 1999 Registrar



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q 21, 220

		Certificate of Death	Reg.	799 24230 No.					
veician	Decedent's Name (First, Middle, Last)	1 1	2. Date of Death Month	Day Year					
nysician Medical	Eva Gentrude Polla		July 25,	1999 9:15 P.M.					
kaminer			Location of Death	4c. County of Death					
neral	Future Care Nursing Home  5. Social Security Number 6. Sex 7. Age (In yrs. last bit	Arnold  orthday) If Under 1 Year   If Under 24 Hrs	8. Date of Birth	Anne Arundel Co.  9. Birtholace (State or Foreign					
ector	216-01-9167 ¹□м ﷺ 85	Yrs. Months Days Hours Min	Dec. 24,1	9. Birthplace (State or Foreig Country) 913 Maryland					
	Usual Rasidenca of Decedent  10a. State 10b. County 10c. City, Tow	n or Location		10d. Inside City Limit					
at be notified at al Director	Marriland James James de la Co	verna Park		1 ☐ Yes 2 1 ☑ N					
	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?					
		U.S.A.							
kner must Funeral	11. Marital Status 12. Wes Decedent Ever in U,S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Rece - American Indian, Black, White, etc.					
by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 □XNo Specify:		Specify: White					
Completed	15. Decedent's Education 16a (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of wo	orking 16b	. Kind of Business/Industry					
dwo	Elementary/Secondary (0-12) College (1-4or 5+) N/A	Machine Operator	TATO	estern Electric					
		-	me (First, Middle, Maid						
To Be	Dominic Kasubinski	Lotti	e Pulaski						
	19a. Informant's Name/Relationship (Type, Print)	o. Meiling Address (Street and Number or R 9 Roberts Road Newto							
	20s Mathed of Disposition 20h Place 0	I Disposition (Name of	Date I and	Leasting City of Town State					
	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Othar (Specify)	or crematory or other place) Cross Cemetery July	30,1999 Ba	ltimore, Maryland					
	21. Signature of Funeral Service Conses	22. Name and Address of Facility							
de diministration de diministr	McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Ave. Baltimore, Maryland 21225								
	23a. Part1. Enter the distant, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter the mode of dying, such as cardia	c or respiratory arrest,	Approximate Interval Between					
	7 0			Onset and Death					
	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):								
min	a duanc	ed dene	Ma	year					
Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  Due to (or as a consequence of):								
edical	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								
an	d								
by Physician/M	Part II. Other significant conditions contributing to death but not resulting in	n the underlying ceuse given in Part I.	23b. Did tobec	co use contribute to the cause of death					
Ph	history of major depu	ession recurre	M 10 Yea	2 No 3 Probably 4 Unknow					
D		1 . 0	24a. Was en eu						
Completed	coronary arreny viseas	de arriar	performed	available prior to completion of cause of death?					
E O	fibrillation paromake	or husestende	1 Yes	2000 1 Yes 20 No					
Be		26. Place of De	eth (Check only one)						
2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou		Homa 5 Residence	6 Other (Specify)					
on:	27. Menger of Death  28a. Dete of Injury (Month, Day Year)  28b. Time of Injury at Work?  28d. Describe how injury occurred Work?								
Cat	2 Accident investigation 3 Sulcide 6 Could not be	M 1 Yes 2 No	204 Leasting /Ctmat	Land Number of Pourl Pourle Number					
Certification:	Suicide  4 Homicide  4 Homicide  4 Homicide  4 Cotol flot be determined  4 Homicide  4 Route Number or Rural Route Number of Rural R								
edicai C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge (Check only one)  Certifying Physician: To the best of my knowledge (Check only one)	e, death occurred et the time, date and place id/or investigation, in my opinion, death occ	e, and due to the cause aurred at the time, date a	e(s) and menner as stated. and placa, and due to the cause(s)					
M	29b. Signature and title of certifier	29c. License number	294.1	Date signed (Month, Day, Year)					
	munge	24 D4191	-5	7-29-99					
1	30. Name and address of person who completed cause of death (Item 23a)	(Type, Print)	1, 5	Maria Carlo he					
	A 1	To a Hele	the su	verna much					
	Debecca Elonmy 979	Jumpers 1700	169	0 1114					
State	31. Date filed (Month, Day, Year) AUG 03 1999	Jumpers How	74	21146					

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### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth **Physician** 45 PM 29 · /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Facility Neme (If not institution, give street end number) **Examiner** EVINDALE MORE If Under 24 Hrs. 8. Dete of Birth Hours Min. (Month, Dey, Yeer) If Under 1 Year Birthplace (State or Foreign Country) / 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Deys 83 1□M 2K)F Yrs Va 215-30-5640 Director Usuel Residence of Decedent with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be not the dealers. Baltimore Ma NA 1 Yes 2 □ No Director 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number 21215 U.S.A arcissus Funeral 14. Rece - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 11. Meritel Status 1 Never Merried 2 Merried ☐ Yes 2 Yes, Give 1 Yes 2 No Specify: Specify: Black þ 3 1 Widowed 4 □ Divorced Year or Detes Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 6b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) 54 NA TRIVate land 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Amos George Finner Mary 19e. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rure! Route Number, City or Town, State, Zip Code) 718 5 nt of Haalth : If item 27 i Granddaughter Narcissus Illiams Avenue 100 more, 20b. Piece of Disposition (Neme of Dete 20c. Location - City or Town, Slete 20e. Method of Disposition Pages 1 Buriel 2 Cremelion 3 Removel from State cemetery, cremetory or other piece) Department of Important: If any Injury or once. Donetion 5 ☐ Other (Specify) 21. Significant of Funerel Service Licensee emonal Parte a 22. Name end Address of Fecility Ballo 2/2/5 00 Md Walnest grenue Approximete Intervat Between Onsel end Deeth 23e. Per 1. Enter the visease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest shock, or heart dalure. List only one cause on each line. **Physician** /Medical Immediete Ceuse (Finel disease or condition resulting in deeth) Examiner Examiner and-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760. mendens (or es e consequence of): Physician/Medical 94 attending pt 23b. Did tobacco use contributa to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown signed b à 24e. Was an autopsy 24b. Were eutopsy findings evailable prior to Completed completion of ceuse of deeth? page 2: ä 1 Yes 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical examiner? 26. Piece of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 2 1□ Yes 212No 1 Inpalient 2 ER/OutpetienI 3 DOA 4 28a. Date of tnjury (Month, Dey Year) funeral 28c. Injury et Work? 28d. Describe how Injury occurred 27. Mannae of Death 28b. Time of Certification: 5 Pending investigation Attending Natural 1 1 Yes 2 No 2 Accident after deat Director: 3 Suicide 6 ☐ Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide b 24 hours 29a. Certifier (Check only one) 1 Certifying Phyalcien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the ceuse(s) Medical end menner steted. To the 7 29b. Signature and title of certifier 29c. License number 29d. Dele signed (Month, Dey, Year)

who completed cause of death (liter Cla) (Type, Print)

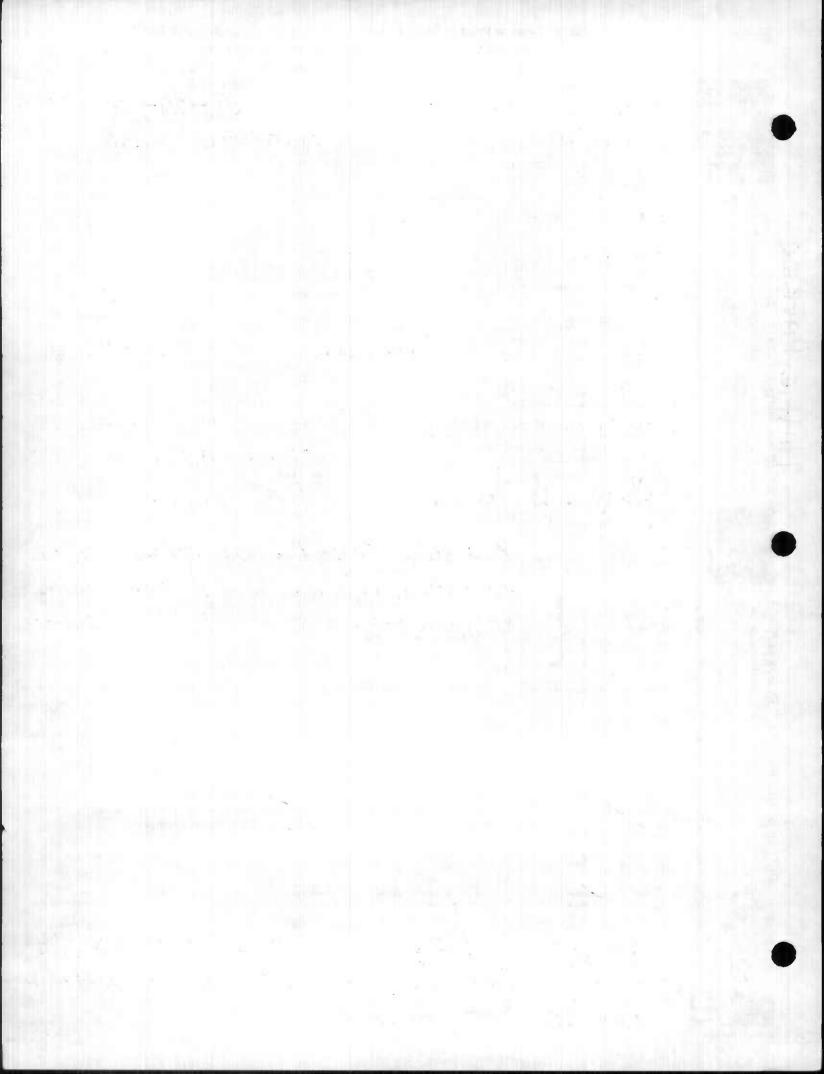
32. Registrer's Signeture

Registrar

11. Dete filed (Month, Day, Yeer)

AUG 0 3 1999

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Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. 24240 State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Oweth 2. Date of Deeth Month 07 Dev **Physician** LOBERT ROBINSON 0400 30 /Medical 4e Fecility Name (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** SECOURS HOSPITAL If Under 24 Hrs. 8. Data of Birth Hours Min. (Month, Day) 7. Age (In yrs. last birthday) If Under 1 Yaer 6. Sex. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Months 220-38-590 6 Yrs. Director YLAND the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Hygiene. other than "natural", or items 28s or 28s-f show ent, the Modical Examiner must be notified at BALTIHORE CIT 1 Yas 2 □ No Director MARYLAND 10g. Citizen of Whet Country? 10e. Street and Number death with 802 12. Was Decedent Ever in U.S. Armed Forces? USA.

14. Rece - American Indien,
Bleck, White, etc. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status hours after 1 Never Merried 2 Married 1 Yes 2 No If Yea, Give Yeer or Detes: 1 Yes 2. No Specify: à BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) HOSPITAL TOUSE KEEPER 7 is marked other traumatic svent, p 17. Father's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumema) Be Pages 1 and 2 should be and Mental COBERTSON SIMMS 2 KOBERT VIOLA 19a. informant's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 20b. Place of Disposition (Neme of cemetery, cremetory or other place)

BENTALOU ST, BALT? HORE MD. 2 12 16

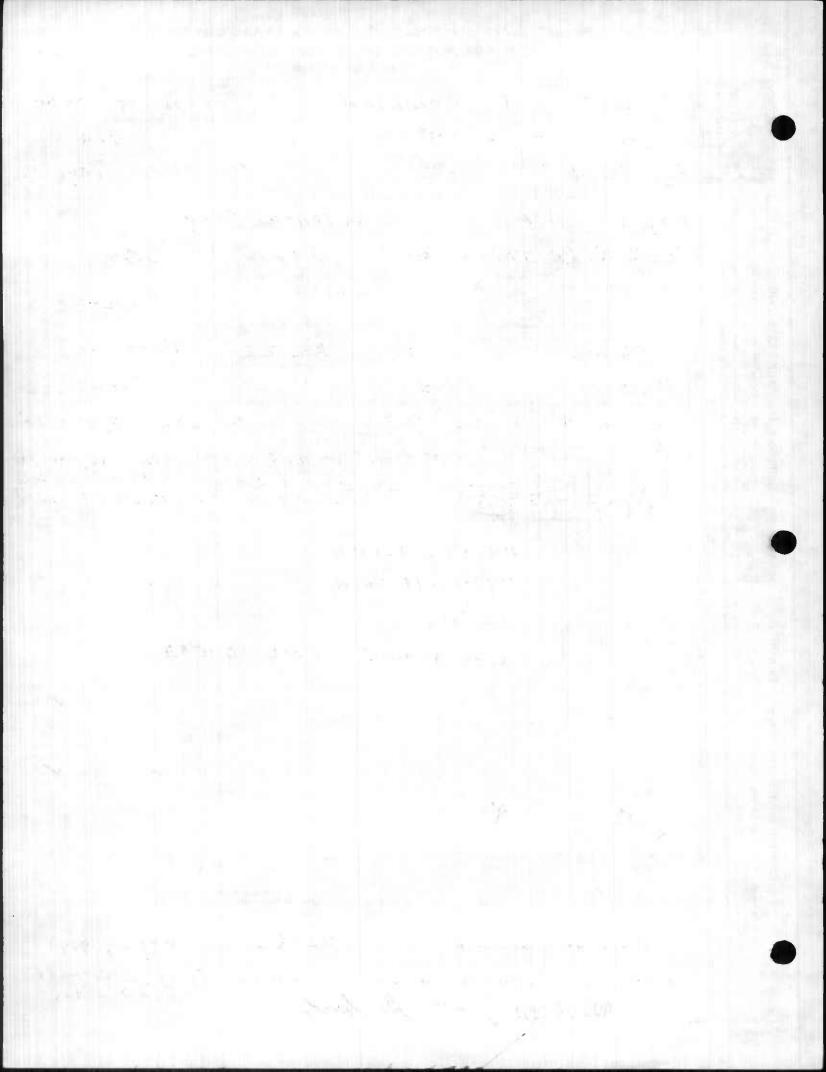
20c. Location - City or Town, Stele Haaith a FLORENCE HIGGINS (COUSIN) mportant: If Item 27 any injury or other tr 20a. Method of Disposition

10 Buriel 2 Cremation 3 Ramoval from Steta to permit. Page Department 4 ☐ Donation 5 ☐ Other (Specify) ZION CEMETERY AUG4, 1999 LANSDOWNE, MARYLAND 22. Name end Address of Facility BROWN JR. FUNERAL HOME f Funeral Sy JOSEPH H. BROWN UK. PUNERAL HOM 2140 N. FULTON AVE. BALTO, MO. 2121 er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, heart failure. List only one cause on each line. Approximate Intervel Betwee Onset and Deat **Physician** /Medical Immediete Ceuse (Final HYPOTENSION diseese or condition resulting in death) Examiner Due to (or as e consequence of) Examiner HYPOGLYCEMIA physician and s the burial-transit requires that the death cartificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events rasulting in deeth) Last Due to (or as e consequence of): SEPSIS Physician/Medical Dua to (or as a consequence of): attanding r 88 RENAL DISEASE STAGE 23b. Did tobacco use contribute to the cause of death? signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. o 1 Yee 2 No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings evalleble prior to completion of cause of deeth? been si 24a. Wes en eutopsy performed? Completed AR cartificate has t The 1 ☐ Yes 2 No 2 No 1 TYes Division of Vital or Attending Physician: director, Be 25. Wes case referred to medical axaminer? 26. Place of Deeth (Check only one) Inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 Yes 200 No Certification: To this funeral 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred Aftar Neturel 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al complately filled in by the fu invastigation 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 ☐ Homicide Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signatura and title of certifier 29c. License number 242683 Reschife in monegraph 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) W NORTEAN PKWY, BATTIMORE RADULISTE ntombs No 4000 31. Dete filed (Month, Dey, Year) 32. Registrar's Signature State AUG 03 1999 Registrar

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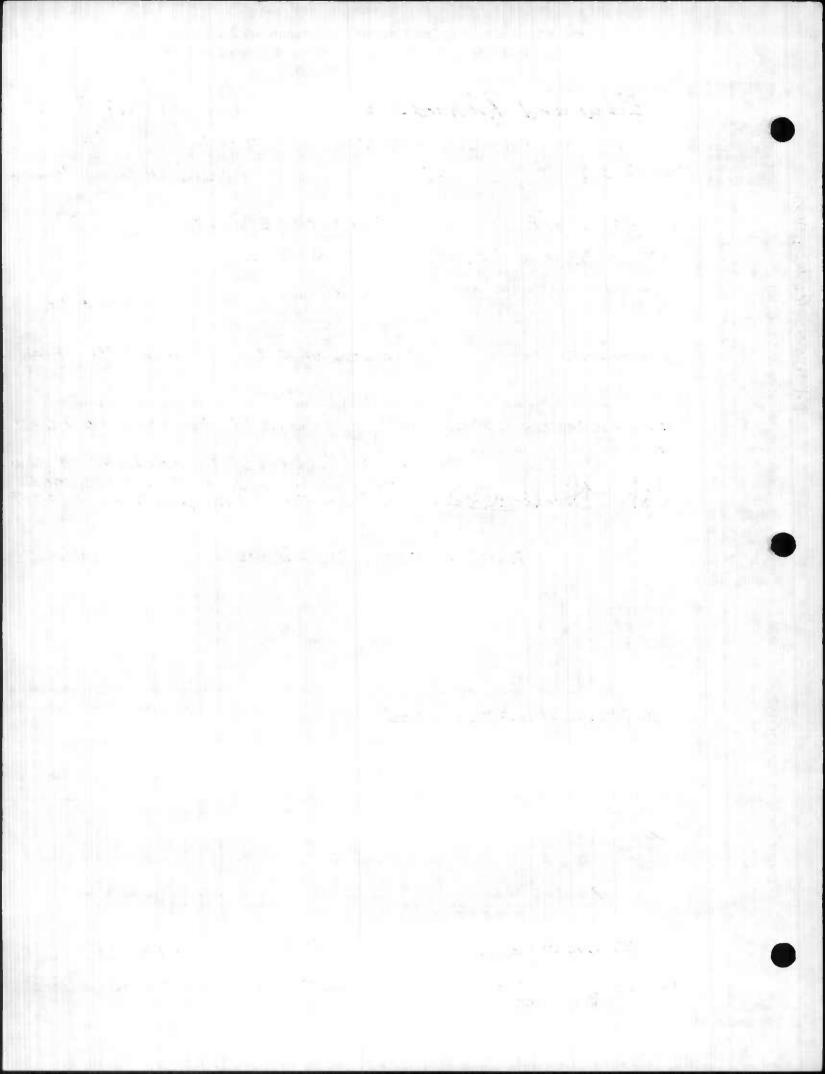
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Registrar

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	State of Maryland / Depa	rtment of Health and Matricate of Death	Mental Hygiene 9	24241			
Dhuninian	Decedent's Name (First, Middle, Last)		2. Dete of Deeth Month Dev	3. Time of Deeth			
Physician /Medical	Edward Kichards	9 0	July 29 1	999 1:30 pm			
Examiner Funeral Director	4e Facility Name (If not institution, give street end number)  VILLA ST. MICHAELS NURSING  5. Sociel Security Number  6. Sex  1 M M 2 F  1 M 2 F  1 Usuel Residence of Decedent	HOME BALT If Under 1 Yeer If Under 24 Hrs. Months Deys Hours Min.	ocation of Deeth 4c. County  MORE  8. Date of Birth (Month, Dey, Year)  APRIL 12, 1916	9. Birthplece (State or Foreign South CAROLIN			
h the Maryland r 28a-f ahow Inctiled at	10a. Stete 10b. County 10c. City, Town or Loc	BALTI MORE	CITY	10d. inside City Limits  1. Yes 2 □ No			
urs after death with urs 23 to thems 23 to the urs 23 to t	1 Newer Married 2 Married 1 Vec 20 No	10f. Zip Code  2/2/2  Vas Decedent of Hispanic Origin? (Sr. Yas, specify Cuban, Mexican, Puarto  Yes 2 No Specify:	10g. Citizen of	Whet Country?  S.A.  ce - American Indien,  ck, White, etc.			
72 ho	15. Decedant's Education 16e. Deced (Specify only highest grade completed) (Give I	ent's Usuel Occupation kind of work done during most of work O NOT use retired)	16b. Kind of B	Jusiness/Industry			
d 2 should be filed within 72 hor by and Mental Hygiene. T's marked other then "nature traumatic evant, the Mental To Be Completed	Elementery/Secondery (0-12) College (1-4or 5+)  6 TH GRADE  17. Father's Neme (First, Middle, Last)	EELWORKER 18. Mother's Nerr	STEE	L COMPANY			
end 2 should ealth and Men n 27 is marks her traumatic	19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailin	Q Address (Street end Number or Ru		, Stete, Zip Code)			
te be executed Tay and the permit. Peges 1 e permit. Permit. Peges 1 e permit. Peges	Immediate Ceuse (Finel disease or complications that caused the death. Do not enter disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Disease or injury  Co.	ny THOMBOS uence of):	or respiretory arrest.	NERAL HOME MORE MO 2/21/ Approximate Interval Between Onset and Deeth			
	resulting in deeth) Lest						
es that the deeth igned by the ette be deteched for by Physicia	Part II. Other significant conditions contributing to deeth but not resulting in the un PEM IPITEARL VASCUUM DISTASE		23b. Did tobacco use co	ontribute to the cause of death?  3 Probably 4 Onknown			
ew requir			24e. Was en eutopsy performed?	24b. Were autopsy findings available prior to complation of cause of death?			
			1□ Yes 2□No	1 ☐ Yes 2 ☐ No			
s certificate director, peg O Be Co	25. Wes case referred to medical exeminer?  Hospitel: Hospitel: Other: A Company of the company						
tranding Ph death. stor: After th / the funeral	27. Menner of Death 1   Inpatient 2   ENOutpetient 3   DOA   4   ENdursing Home 5   Hesidence 6   Other (Sp. 2   Menner of Death 1   Menter of Injury   28b. Time of Injury   28						
its or its after all Direction Cent	4 Homicide determined 2se. Pieca of Injury - At home, farm, stre building, etc. (Specify)  29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth		City or Town, Stete)				
n 24 hound no 24 hound no Fune pletely fill bedical	(Check only one)  2 Medical Examiner: On the best of my knowledge, deem one)	estigetion, in my opinion, death occu	rred et the time, date end plece	, and due to the ceuse(s)			
To the comp	29b. Signature and title of cartifier  Notional A Region	29c. Licensa number		ed (Month, Day, Year)			
State	30. Name end eddress of person who completed cause of death (Item 23e) (Type, F  DR. DEBORAH PIECE 72 20  31. Dete filed (Mont) PICY (12) 4000 32. Registrer's Signature	H45931 PARK HEIGHTS	AVE, BALTO.	MD. 21208			

Please Type or Print In Black Indelible Ink. Assure Ail Copies Are Legible.



MENDED ITEM #1	PER MD G774 8/6/99 AH	State of Maryl			of Health and of Death		Reg. No.	99	24242
Physician /Medical	MILLIAM	H RUHL	UHLMANN			2. Data of D Month	Day	Year 99	3. Time of Death 21;34
Examiner	4s Facility Name (If not institution, give STAGNES	TEALTHC.	ARE	if Under 1	BALTI	MORE	N/A		
Funeral Director	5. Social Sécurity Number 6. Se 218 07 8205	2X 2 F 85	yrs. last birthday Yrs.			in. (Month, E	irth Day, Year) /1914	9. Birthi Cour M	place (Stata or Foraign ntry) D
rith the Maryland or 28a-f ahow	10a. State         10b. County           Md         N/A	10c.	City. Town or L Balti					1	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
ter deeth with the Maryle terms 23e or 28e-1 should treatment be notified at Euneral Director			2 2 7	10g. Citizen of What Country? USA					
O20 ore of	3€ Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  15 Eves 2 □ No if Yes, Give Year or Dates: ₩ ₩	Elyes 2 □ No □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □			of Hispanic Origin? (Specify Yas or No- uban, Mexican, Puerto Rican, atc.)  14. Race - An Black, Who Specify:  Specify:			
21215-0020 ed within 72 hours aft yolene, than "natural", or if, the worker Error Completed by F	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	college (1-4or 5+)	16a. Dec (Giv. lifa.	edent's Usual C a kind of work of DO NOT use r	occupation lone during most of v etired)	working	16b. Kind of	Business/In	dustry
Maryland 2 d 2 should be filed in the and Mentel Hygh in marked other traumatic event.	17. Father's Name (First, Middle, Last)	n				lama <i>(First, Middl</i> ra Fair			
2 9565	19a. Informant's Name/Relationship (7) Elsie Cageby/Si	.,	100000000000000000000000000000000000000		treet and Number or				
Baltimore, permit. Pages 1 en Department of Heal Important: If Nem 2 en y Injury or other page.	20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from Stata  4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cernatory or other place)  Balto-Wash Crematory 8/3  Laurel, Md.								
Ball permit Dopent Import Import Environ	21. Signature of Funeral Service Licens  May William  23a. Part1. Enter the disease, or compendock, or heart feilure. List only of	urshall	5	terli	mondson	Avenue,	Balto		Approximate Interval Between
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a. VQ V	nthi Cu		arrhyt	hmias		1	10hours
.O. Box 68760, the death certificate be executed by the ettending physician and sched for use as the buriel-transit hysician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С	O (or as a conse						20 year
O # ## &	Part II. Other significant conditions co	ntributing to death but not	resulting in the	underlying caus	se given in Part I.		d tobacco use c		o the cause of death'
Record  I law requir  has been a  ge 2 should  mpleted						per	s an autopsy formed?	av co of	Pere autopsy findings vailable prior to impletion of cause deeth?
	25. Was case referred to medical	Hospital:	2 ☐ ER/Outpatie	nt 3 DOA	Othor	Deeth (Check only		ther (Specia	fy)
siding ending eeth. or: After the fune	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Data of Injury (Month, Day Year		М	Injury at Work? 1 Yes 2 No		Street and Nur		al Route Number,
28.50	4 Homicide determined  29a. Certifier 1 Certifying Phy	28e. Place of Injury - A building, etc. (Spontage)	ecify) knowledge, dea	th occurred et ti	he tima, data and pla	City or To	own, Steta) e cause(s) and r	mannar as s	stated.
To the Keep within 24 hours To the Funan completely III	(Check only 2 Medical Exami	ner: On the basis of axam and manner stated.	inetion and/or i	vestigation, in	my opinion, deeth oc	curred at the time	29d. Date sign	e, and due to	o tha cause(s)
	30. Name and address of person who co	4		D	590			07	131/99

State

296. Signature and title or cerum.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR BARIFI OPARE-ADDO 2502 W. PATTAPS CO 28 BALTIMORE MD 21230

31. Data filed (Monta Pig 1973) 1999

32. Registrar's Signature

4. Apartial

Registrar

in the second

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Day 1999 July 31 **Physician** MARGARET W. REMKE 2:40 p.m. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 2008 Gumtree Terrace Bel Air Harford 5. Social Security Number If Under 24 Hrs. 8. Dete of Birth Dec. 1, 1909 Birthplece (State or Foreign Gountry)
 Ond 7. Age (In vrs. last birthday) **Funeral** 1□M 2ØF Months Deys Hours Min 89 Yrs Director 233-10-2163 Usual Residence of Deceden the Maryland 10a State 10b Count 10c. City. Town or Location t0d. Inside City Limits 28a-f show 1 ☐ Yas 2 X No Director MD. Bel Air Harkord 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ death with 2008 Gumtree Terrace 21015 herns 23a U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: 11 Marital Stetus Wes Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental hygiene. Important: if Item 27 is marked other than "natural", or hen any injury or other traumatic avant, the Medical Exercises pages. Bleck, White, etc. 1 ☐ Never Married 2 ☐ Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: p White. 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) years Register Nurse State of West Virginia 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maidan Surname) Be Mary Isabelle Johnson Thomas Williams 19e. Informent's Neme/Raletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Linda R. Lemasters (Daughter) 2008 Gumtree Terrace. Bel Air. MD. 20b. Place of Disposition (Nama of cametery, crematory or other place) 20a. Method of Disposition Deta 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 □ Donation 5 □ Other (Specify) 8/4/99 Stone Church Cemetery Elm Grove, W. VA. 22. Name and Address of Fecility Schimunek Funeral Home of Bel Air, 21. Signature of Funeral Service Licenses Inc. Bel Air, MD. 610 W. MacPhail Road, 21014 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finet ear disease or condition resulting in death) Examiner Dua to (or as a consequence of) Examiner burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieled events resulting in death) Last and Due to (or es a consequença of). physician the burial Box 68760. Physician/Medical Due to (or as a consequence of): 080 signed by the a d be detached f Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the causa of death? Division of Vital Records. P.O. 1 Yes 2 No 3 Probably 4 Unknown þ Completed 24a. Was an autopsy performed? 24b. Were eutopsy findings evailable prior to completion of cause of death? page 2 2 NO 1 Yas 2 No 1 Yas certificate after death.

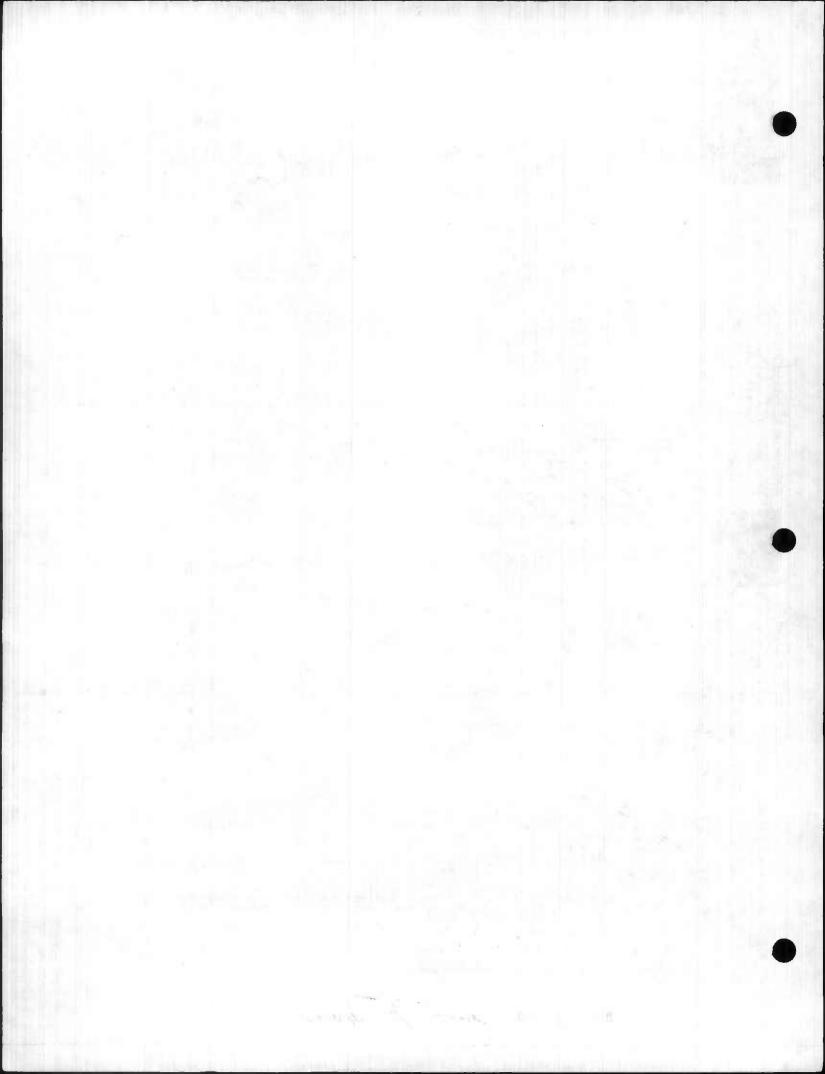
Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only ona) Other: 4 Nursing Homa 1 Yas 2 Certification: To 1 Inpetient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 27. Manner of Death 28d. Dascribe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. tnjury et Work? Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of tnjury - At home, ferm, street, factory, offica building, atc. (Specify) filled in by 4 Homicide 24 hours a Hospital Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at tha time, date end piece, and due to the cause(s) and mannar as stated.

[2] Medical Examiner: On the basis of examination and/or investigation in my opinion, death occurred at the time, date and place, and due to the completely (Check only one) On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and menner stated. To the I 29b. Signature and the of 29c. License number 29d. Date signed (Month, Dey, Year) 30. Neme and addrass of person who completed causa of death (Item 23a) (Type, Print) 0 1 Cu CH INDA 6 31. Date filed (Month, Day, Year) 32. Registrac's Signature State

DHMH 16 Rev 6/95

Registrar

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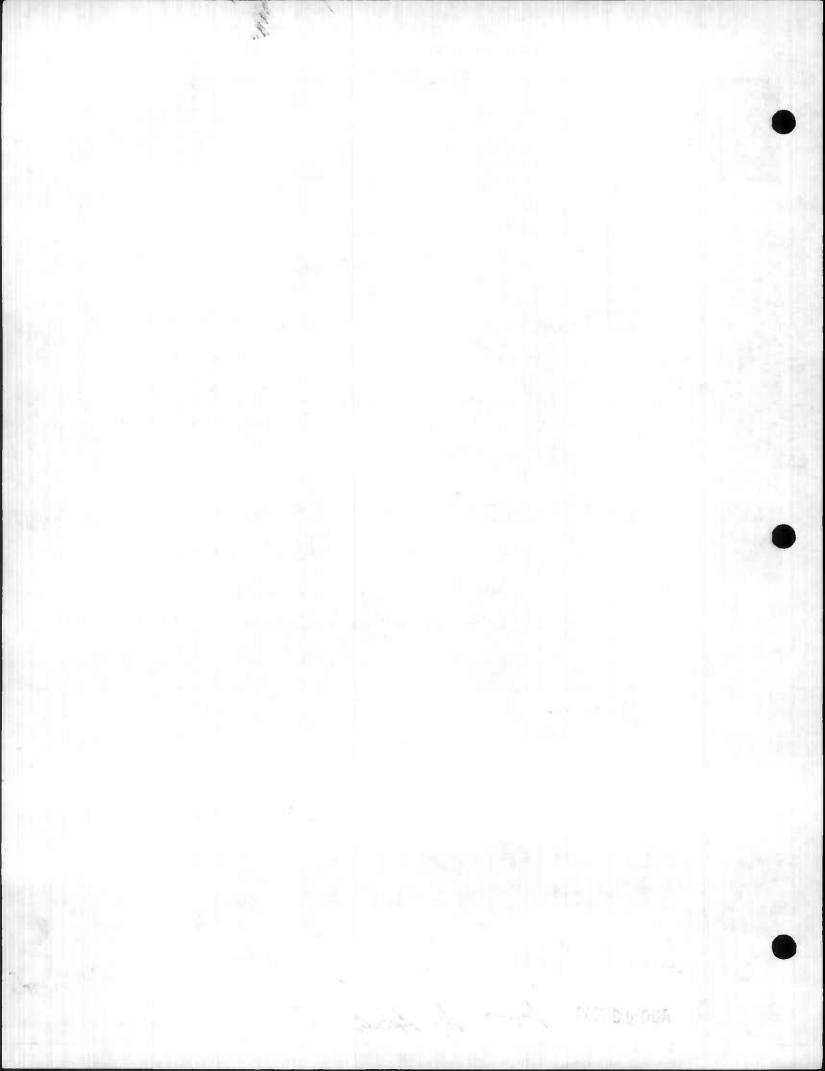


### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 43 PM **Physician** 2 U /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) Examiner timore Dna Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last.birthday) **Funeral** Days 238-20-1740 Usual Residence of Decedent 1 M 2 F Director 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow 1 Yes 2 No Director Maryland ore 2847 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? mast be n Funeral di d Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If Item 27 Ie marked other than "natural", or Items eny Injury or other traumatic event, the Medical Examinar m. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Stetus 1 Never Merried 2 Married Maryland 21215-0020 1 Yes 2 No Specify Be Completed by 3 NWidowed 4 □ Divorced Yaar or Detes tmerica HITO 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) Elementary/Secondary (0-12) College (1-4or 5+) PI 17, Eathar's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) 19a. Informant's Name/Reletionship (Type, Print) (1949) 19b. Meiling Address (Street and Number of Aural Floure Number, City or Town, State, Zip Code) TO aitimore, 20b. Place of Disposition (Neme of 20a. Method of Disposition Day 20c. Location - City or Town, Stata netary, crematory or other piece, 1 Buriel 2 Cramation 3 Removel from State 3 4 ☐ Donetion 5 ☐ Other (Specify) 20 22. Name and Address of Facility 21. Signature of Funerel Service Doensee Home tuneral S Joseph 2222 V Aue. W. North Balto. Md. 21 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heert failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Fine disaasa or condition resulting in death) Examiner Due to (or as a consequence of) Examiner The iaw requires that the death certificate be executed the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last P.O. Box 68760, gensa Physician/Medical Due to (or as a consequence of) USB 88 signed by the atter Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Inaame 3 Probably 4 tonknown 1 ☐ Yee 2 ☐ No of Vital Records, Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an eutopsy performed? certificate has 1 Yes 20 No 1 Yas or Attanding Physician: 80 25. Was case referred to medical examinar? 26. Place of Deeth (Check only one) Other: 4D Nursing Home 5 Residence 6 Other (Specify) edicai Certification: To 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) funaral 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Neturel To the Hospital or Attending within 24 hours after death. To the Funerel Director: Aft 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29b. Signature end title of cartifier M)) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHOA(13 A. HASTHM), S2( N Entaw St Sonte 308 Balt mD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Virginia Sauerwald 1999 July 30 4:20 PM /Medical 4e Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** CAtonsville Commons Nursing Center Catonsville Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dey, Year) **Funeral** Months Days 1 M ZONE Hours 218 14 1065 82 April 25,1917 Director Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits appa Baltimore Baltimore 1 Yas 2 No Maryland Directo 28a-f 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? ò 6 Edmondson Ridge Rd. 21228 United States Norms 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces?

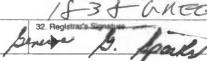
1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Merried 2 Married 8 Baltimore, Maryland 21215-0020 1 Yes ZONo Specify: White Specify. à 3 XWidowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiens. Elementary/Secondary (0-12) 12 College (1-4or 5+) Food Server and Preparer Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be in ment of Health and Mental H lant: If Item 27 is marked off jury or other traumatic even Be Henry Wilson Tracy Grace McKenzie 2 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5002 Edmondson Ave., Baltimore, MD Nancy Stanton / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremetion 3 ☐ Removal from State 8/2/99 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory Baltimore, MD 22. Name and Address of Facility CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, 21286 MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart tailure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediete Cause (Final disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): physician s the buria Box 68760. Physician/Medical Due to (or as a consequence of): 98 Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 4 Dunknown 1 Yee 2 No 3 Probably OBSING Completed by 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 1 ☐ Yes 2 ☐ No certificate 1 Yes of Vital or Attending Physician: director 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) 1 Yes 2 Other: 4 Deriving Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Sath 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Affer Division Watural 5 Pending 24 hours after death.

Funeral Director: Al 20 Accident 1 Yes 2 No investigation 6 Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital Titying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mariner as station.

| The best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier completely (Check only one) within 2 \$ 29b. Signature and title of certifie 29d. Date signed (Mahth, Day,

2 x 2

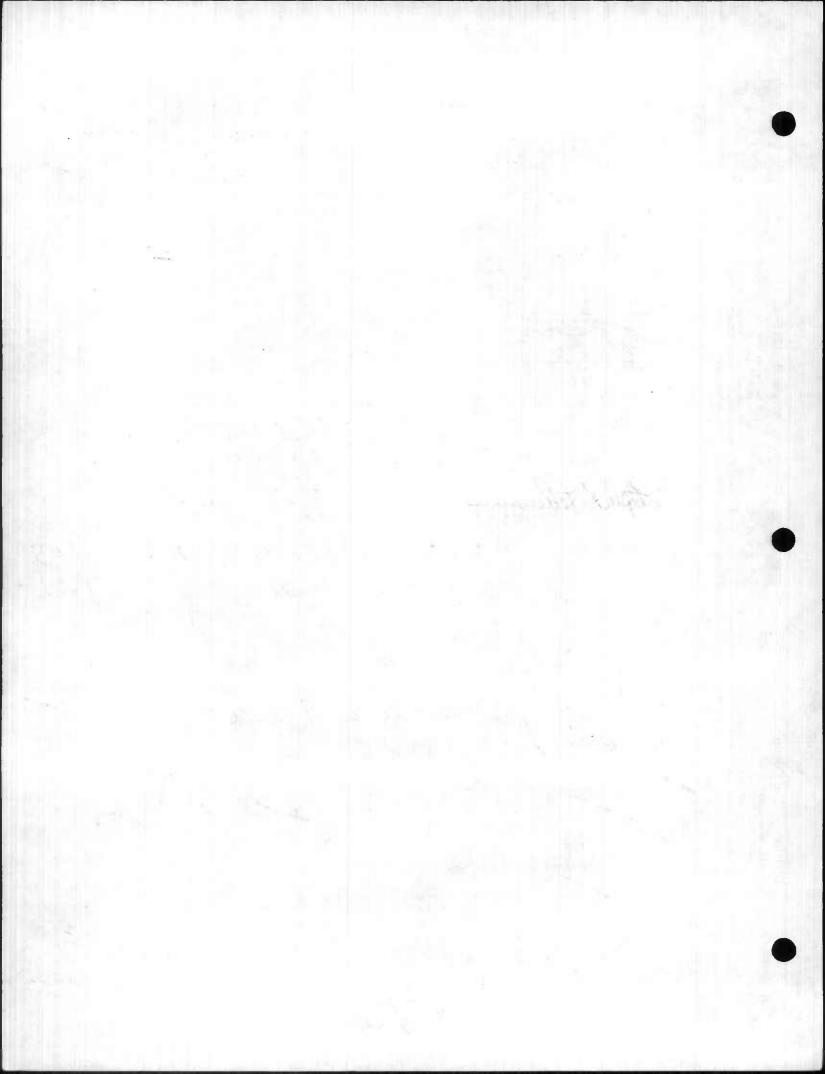
State Registrar AUG 0 3 1999



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

CESVICLEMI



### Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death **Physician** AUGUST Charles James Smith /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CATON MANORGENESIS ELDER CARE BALTIMORE If Under 24 Hrs. If Under 1 Yaar 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 11 M 2□ F 91 218-03-0641 **Director** Sept. 18, 1907 Usual Residence of Decedent the Marylend 10a State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23s or 28s-f show trsumstic event, the Medical Examiner must be notified as Director Maryland n/a Baltimore 10e. Street and Number 10f. Zip Code with 3330 Wilkens Avenue 21229 Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after to Department of Heelth and Mental hygiene. Important: If item 27 is marked any injury or other. 1 Naver Married 2 ☐ Married 1 ☐ Yes 2 No Specify: p 3 Widowed 4 Divorced Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 6 wallpaper hanger 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middla, Maidan Sumama) Joseph T. Smith Mary Musgrove 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 1218 Glyndon Avenue, Baltimore, Maryland Audrey Smith - sister 20b. Placa of Disposition (Name of cemetery, crematory or other placa) 20a. Mathod of Disposition 1 ☐ Burlal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 21. Signature of-Funeral Service License 23a. Part1. Enter the disease, or conclusions that causad the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line.

8/4/99 Baltimore, Maryland 22. Nama and Addrass of Facility Loudon Park Funeral Home 3620 Wilkens Avenue Baltimore, Maryland Approximata Interval Between Onspt and Death Due to (or as a consequence of): Due to (or as a consequenca of):

26. Plece of Death (Check only one)

Green Thee Rd

**Physician** /Medical Examiner

certificate be

Examiner Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Physician/Medical Part II. Other signified in conditions contributing to death but not resulting in the underlying cause given in Part t. p

physician and s the burial-trans esn the signed by the Completed funeral director Be 2

hes

Hospital or Attending Physician:
 24 hours after deeth.
 Funeral Director: After this certific.

To the Within 2

Division of Vital

Immediate Ceuse (Final disaase or condition resulting In deeth)

25. Was casa referred to medical examiner? 1 Yes 2 No

27. Manner of Deeth 5 Pending Investigetion 2 Accident 6 Could not be determined 3 ☐ Suicide

4 Homloide 12 Certifying Physician: To the beer of my knowledge, death occurred at the time, date end placa, and due to the cause(s) and manner es stated.
2 Madical Examiner: On the belis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier

2 Madical Exa

28a. Date of Injury (Month, Day Year)

28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Tima of

28d. Describe how injury occurred

Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

24a. Was an autopsy

1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifing

AUG 0 3 1999

cruse of death (Item 23a) (Type, Print)

28c. Injury at Work?

1 Yes 2 No

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene

29d. Date signed (Month, Day, Year)

23b. Did tobacco usa contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Minknown

24b. Ware autopsy findings available prior to

completion of cause of death?

1 ☐ Yes 2 ☐ No

3. Time of Death

Birthplace (State or Foreign Country)

10g. Citizen of What Country?

United States

16b. Kind of Business/Industry

home improvement

20c. Location - City or Town, State

Race - American Indian, Black, Whita, atc.

White

10d. Inside City Limits

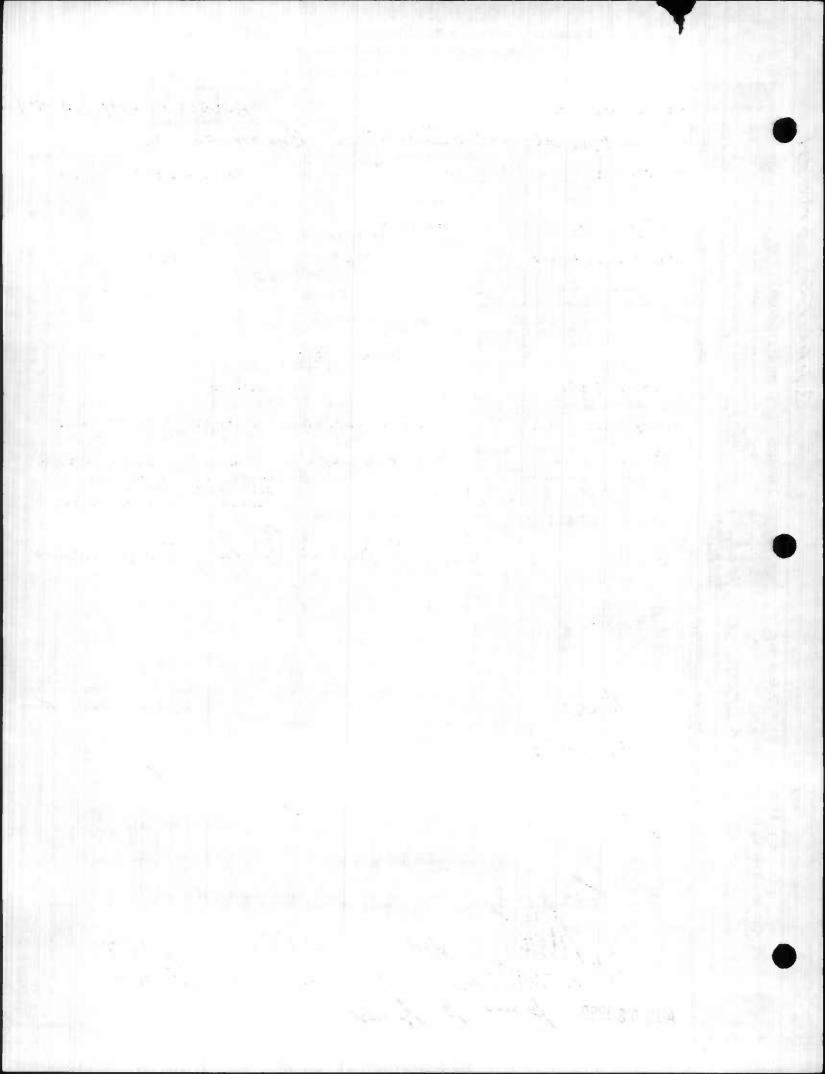
1 Yes 2 No

7:00AM

31. Data filed (Month, Day, Year)

State Registrar

Medical



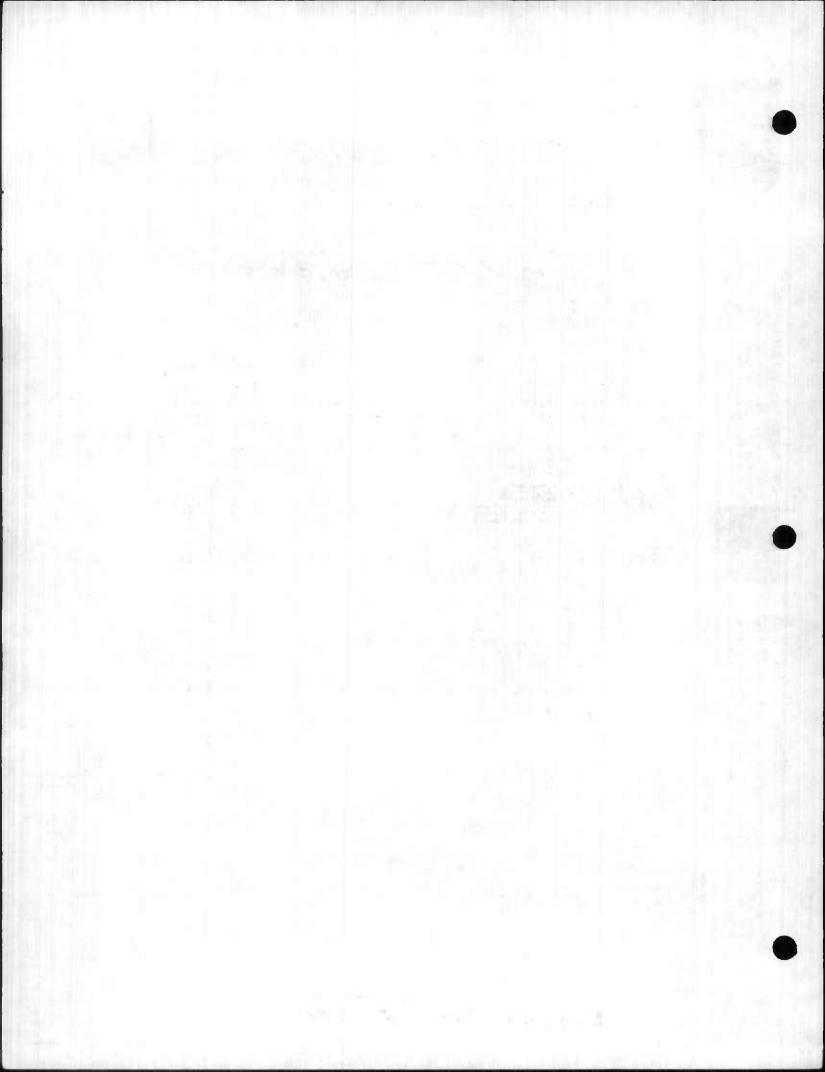
# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dev Year Physician Dorothy /Medical Staley 4b. City, Town, or Location of Death 1999 10:05 PM 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Holy Cross Nursing Burtonsville Montgomery If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 10M 20F Yrs. Director 280.16,8613 Dec. 6.1922 Ohio Usual Residence of Decedent 10c. City, Town or Location Laurel 10a. State M.D. Ahow 10d. Inside City Limits r than "natural", or flams 23a or 28a-( ahov the Medical Examiner must be notified at Prince Georges 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 7700 Cherry Lane 20707 deeth U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. pemit. Pages 1 and 2 should be liled within 72 hours after of Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or Item any Injury or other traumatic event, the Medical Exemplana. 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Married 1 Yes 2 No Specify: White Saitimore, Maryland 21215-0020 Specify 3 € Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Church 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Unknown Helen Uhlmann 19a. Informant's Name/Relationship (Type, Print) 19b. Meiting Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Cod € 1 2 2 8 4736 Ilkley Moor Ave. Ellicott City, Md. Gary A. Staley/Son 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, cremetory or other plece)
Forest Hill Buriat 2 Cremetion 3 Removel from State
4 Donation 5 Other (Specify) 8/6 Caton, Ohio 21. Signature of Juneral Service Lip 22 Name and Address of Facility tters Sterling-Ashton-Schwab 736 Edmondson Ave. Baltimore, Md. 21228 ease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arreat, ire. List only one cause on each line. **Physician** tmmediate Cause (Final disease or condition resulting in death) /Medical PULMONARY DISEASE OBSTRUCTIVE Examiner Examiner The law requires that the death certificate be executed physician end the burial-transit Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760 Physician/Medical Due to (or as e consequence of): for use as 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. P.O. signed by the a d be detached f 23b. Did tobacco use contribute to the cause of death? CENERAUVASCULAR ACCIDENT 1 Yes 2 No 3 Probably 4 Unknown Records, à 24b. Were eutopsy tindings evailable prior to completion of cause of deeth? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 Tyes 2 Devo this cartificate of Vital Attending Physician: 8 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 11 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funaral 27. Manner of Death 28a. Date of tnjury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. tnjury at Work? Atter Division 1 (DNatural 5 Pending he Hospital or Attending in 24 hours after death. he Funerel Director: After pietely lilled in by the fun 1 Yes 2 No investigation 2 ☐ Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, term, street, tectory, office building, etc. (Specify) 28t. Location (Street end Number or Rurel Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 112 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and menner es stated. Medical To the Hosp within 24 ho To the Fune completely li (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, dete end place, end due to the cause(s) and manner stated. 29b. Signature and title of certifie 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) CHERRY LA LAGREL, MD 20707 CASAS

State Registrar 31. Date tiled (Month, Day, Year)

**DHMH 16 Rev 6/95** 

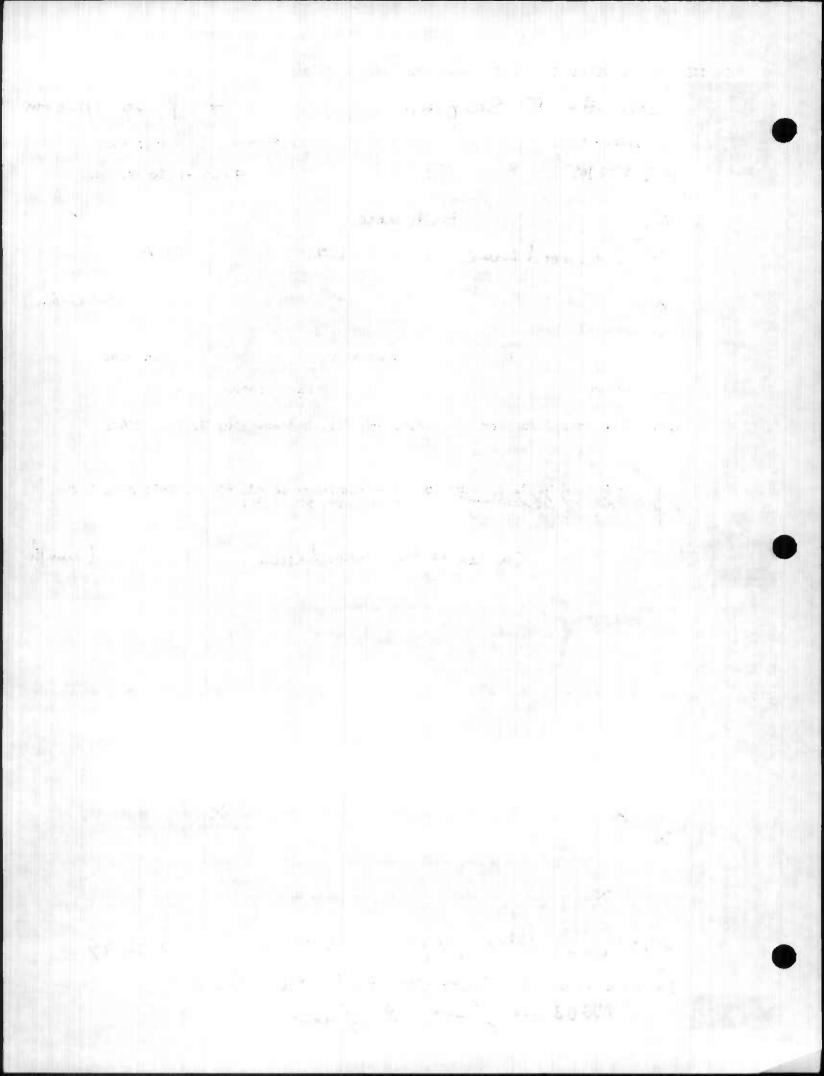
32. Registrar's Signature



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND I	State of Maryland / Depart EM: #24A PER VERBAL RESPONSE G774 8-3-99 WR. Certi	tment of Health and M		ene 99 2	4248		
	1. Decedent's Name (First, Middle, Last)		2. Dete of Death		3. Time of Death		
Physician	Garnette E Simmian		Month	Day Yaar	1:20 Aun		
/Medical Examiner	4a Facility Neme (If not institution, give street end number)	4b. City, Town, or L	ocation of Death	4c. County of Death			
LAGIIIIIEI	8 Judywood Lane	Baltimo	re	Baltimor	0		
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs.	8. Dete of Birth		place (State or Foreign ntry)		
Director	213 342705 10 M 28 F 78 Vrs.	Months Days Hours Min.	(Month, Day, 9 - 26 -	1970 W. V			
,	Usual Residence of Decedent						
how	10a. State 10b. County 10c. City, Town or Local				10d. Inside City Limits		
h the Marylen r 28a-f show Incutied at	MD Baltime	re			1 ☑Yes 2 □ No		
with the Marylend as or 28a-f show	10e. Street and Number	10f. Zip Code		g. Citizen of What Cou	ntry?		
th w	8 Judy wood Lane	21221		WSA			
hours after death v ural', or items 23st Examinet must	11. Meritai Status 12. Was Decedent Ever in U,S. 13. Was Armed Forces?	s Decedent of Hispanic Origin? (Sp 'es, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Rece - Ameri Black, White,			
afte or it	1 Never Married 2 Married 1 Yes 2 X No	Yes 2 No Specify:		Specify: Ca.			
ours a	3 Widowed 4 □ Divorced Yeer or Detes:			Specify. Cat	Marian		
72 Table 14	(Specify only highest grade completed) (Giva kin	nt's Usual Occupation and of work done during most of work	king 1	6b. Kind of Business/In	dustry		
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should be marked o	Jerry Graham	Mary Li					
2 sho and Is m		Address (Street and Number or Ru	rai Route Number,	City or Town, Stata, Zij	Coda)		
		Box 815, Hedgesv:					
semit. Pages 1 er Separtment of Hea mportant: if Item iny infury or othe	20a. Mathod of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)	tory or other place)	Date 2	Oc. Location - City or T	own, State		
permit. Pages Department of Important: If I any injury or once.	Ronald S. Wade, Director Sta	Name and Address of Facility Ate Anatomy Board Limore, MD 2120		Baltimore	Street		
	234. First. Entar the disease, or complications that caused the death. Do not enter			st,	Approximate		
Physician	hock, or heart failure. List only one cause on each line.				Onset and Death		
/Medical	Immediate Cause (Final	cl			1		
Examiner	disease or condition resulting in deeth)  a. Caucal Head of the condition resulting in deeth)	Sometine		1	( mouln		
يَ الكامالية	Dua to 10 sa conseque	inice oi).		1			
executed n and isl-transit Examiner	Sequentially list conditions  Due to (or as a conseque	ince of):					
be executed ician and burial-transit	if any, leading to immediate cause. Enter Underlying						
	that initiated avants  C. Due to (or as a conseque						
as to se	resulting in death) Last						
eath certifice ettending ph for usa as til	d						
death death of for u	Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I.	23b. Did tol	pacco use contributa t	o the cause of death		
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med be dete							
he law requires the law			24a. Was ar		ere eutopsy findings reliable prior to		
The law requirer ate has been so page 2 should			pertorm	ied?	ompletion of cause death?		
The law ate hes page 2:			1□ Ye	V			
certificate rector, pag	25. Was casa rafarred to medical	20.51 45	- '		☐ Yea 2☐ No		
Physician: The conflicate ral director, pa	examiner? Hospital:	Othor	th (Check only one		4.1		
5 00 0	1 ☐ Yes 2 ☐ No	3 DOA 4 Nursing H	28d. Describe ho	nce 8 Other (Speci w Injury occurred	'y)		
ding Atte	1 Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	Work? M 1 ☐ Yas 2 ☐ No					
or Attanding after death. Director: After d in by the fune	3 Sulcide 6 Could not be 28e. Place of Injury - At home, farm, strae	t, factory, office	28f. Location (Str	reet and Number or Rui	al Routa Number,		
tel or Attending P rs after death. al Director: After to led in by the funers Certification:	4 Homicide building, atc. (Specify)						
Hospital 24 hours Funeral nely filled	29a. Certifier 1 Certifying Physician: To tha best of my knowledga, daath o	courred at the time, date and place	and due to the ce	usa(s) and manner as	stated		
To the Hospital or Attanding Physinia 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral Medical Certification:	(Check only one)    Check one)	stigation, in my opinion, daath occu	rred at the time, da	te and place, end due	to the cause(s)		
To the comple	29b. Signeture and title of cartifier	29c. License number	29	d. Dete signed (Month)	Day, Year)		
F3F8	MILLON CHUR MIN	DITUTU		7.21-0	G		
	William Co Stury (M)	DITTET		(- Up-7	/		
	30. Name and addrass of person who completed cause of diffin (fluin 23a) (Type, Pri	Baltin - alle	Daire	1			
	21 Date filed (Manth Day Vocal)	Darling	Jua	21			
State	31. Date filed (Month, Day Year) 32. Registrar's Signature 4.	land.					
Registrar	1000 /- 1000	sporks					

DHMH 16 Rev 6/95



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3 Time of Death **Physician** , 40Pm Wal /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Ridgeway Manor Nursing Home If Under 1 Year Catonsville Baltimore If Under 24 Hrs. B. Date of Birth (Month, Dey, Year) 1 1 / 2 4 / 1 9 2 3 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 12 M 2□ F 217-14-0845 75 Yrs. Director Md Usuai Residence of Decedent with the Marylend 10b. County 10c. City. Town or Location r then "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits 1⊠Yes 2□No Directo Baltimore Catonsville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 290 Bloomsbury 21228 USA Funeral 11. Meritel Stetus 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours efter Hygiene. 1 Never Merried 2 Married tX Yes 2 No Baltimore, Maryland 21215-0020 other than "natural", or 1 Yes MANO if Yes, Give WW Year or Detes.WW Specify þ 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondery (0-12) College (1-4or 5+) Clerk Post Office permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if flem 27 is marked oth any Injury or other traumatic event potes. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) William Shipley Myrtle Wortman 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laurence Shipley/son 6026 Edmondson Avenue, Balto, Md. 21228 20b. Piece of Disposition (Neme of cemetery, cremetory or other piece) 20a. Method of Disposition Dete 20c. Location - City or Town, State XIXBurial 2 ☐ Cremation 3 ☐ Removel from Stete Meadowridge Mem. Park 8/2 Baltimore, Md 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Neme and Address of Facility
Sterling Ashton-Schwab Funeral Home, Mask. Mars 736 Edmondson Avenue, Balto, Md. 23e, Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Deeth Physician immediete Cause (Finel disease or condition resulting in deeth) /Medical mignous cell carcinoma-long Un le moron Examiner Due to (or es e consequence of) Physician/Medical Examiner The law requires that the deeth certificete be assocuted attending physician and for use as the buriel-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Lest Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of geath? signed by t Chame Obstraction Polamon Divare 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy peen Ceretrovaccora recident, Hypertension hes Left lover interity deep verses themson's 1 Yes 2 No 1 TYes 2 No or Attending Physician: Be 25. Was case referred to medical exeminer? 28. Piece of Death (Check only one) 1 Yes 2 No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 this Inneral 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: After t 1 Netural 5 Pending investigation n 24 hours after death.

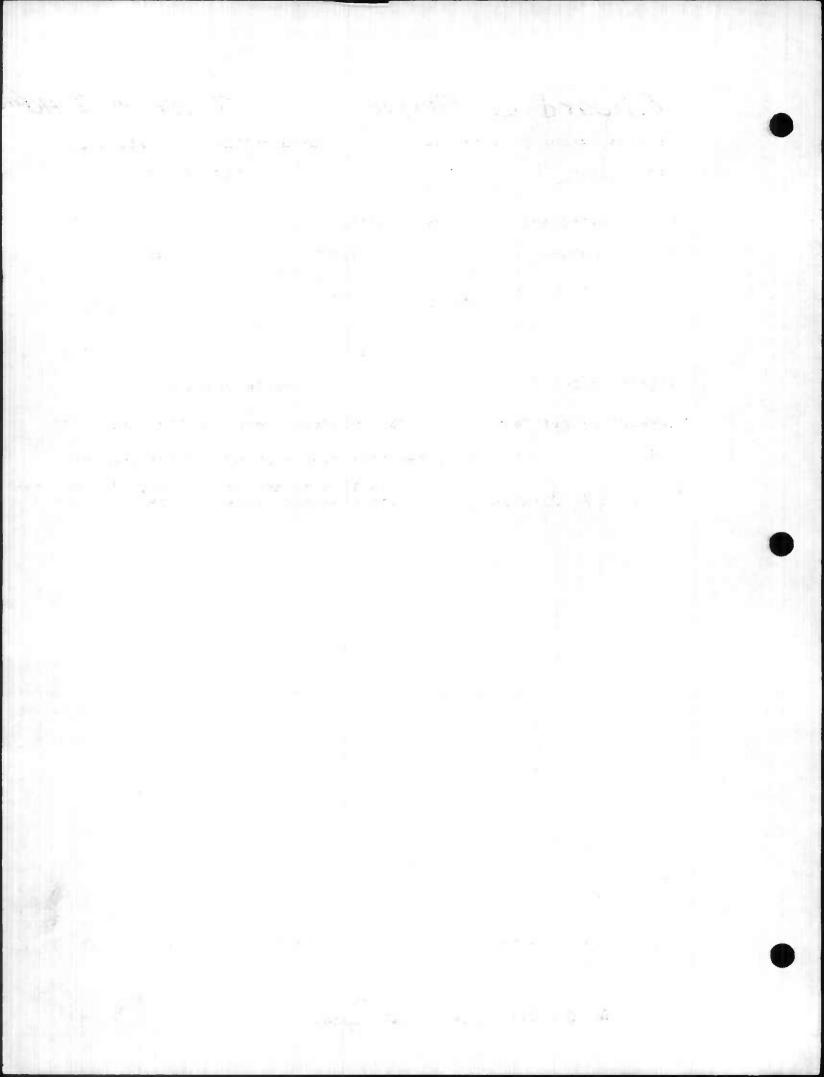
Ne Funers! Director: Af pletsity filled in by the It. 1 TYes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and piece, end due to the ceuse(s) and manner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and piace, and due to the cause(s) end manner stated. 29e. Certifier (Check only one) within 2 29b. Signeture and title of pertifier 29c. License number 29d. Dete signed (Month, Day, Year) Lugares D19667 hillare 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) 5517-A RITEHIZ HWY, MD 21225 SCHWARTZ LIC-14AZ 31. Dete flied (Month, Dey, Year) 32. Registrar's Signeture State

DHMH 16 Rev 6/95

Registrar

AUG 03



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Tima of Deeth Dey Month STITZ 2:07 A.M MARGARET VIRGINIA 4a Facility Name (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE BY If Under 24 Hrs. 8. Good Samaritan Hospital
Social Security Number 6. Sex 7. Age (In yrs. last birthday) CIT 8. Dete of Birth (Month, Dey, Year) If Undar 1 Yae Birthplece (Stele or Foreign Country) 10 M 28 F Hours Min. Months Deys 2/7-/2-332° Usual Residence of Deceder W. 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD BALTIMORE 10g. Citizen of What Country? 10a. Street and Number 10f. Zip Code 3309 NORTHWAY DR.

12. Was Decedent Ever In U.S.
Armed Forces?
1 | Yes | 2 | No
If Yes, Give
Yaar or Detes: USA 14. Race - Amarican Indian, Bleck, White, etc. Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Stetus 1 Nevar Married 2 Merried 1 Yes 2 No Specify 3 Widowed 4 □ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) NIA 12 CLERICAL WESTINGHOUSE 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumema) FLOYD O. ROSS CARRIE ALICE MYERS 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 3309 NORTHWAY DR. BALTO, MD 21234
e of Disposition (Neme of Dete 20c. Location - City or Town, Steta (SON) THOMRS R. STITZ 20e. Method of Disposition

1 Paurial 2 Cremation 3 Removel from State 20b. Plece of Disposition (Name of cametery, crematory or other plece) 8-3-99 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) GARDENS OF FAITH 22. Name and Address of Fecility FUNERAL HOME, P. A. 21. Signature of Funeral Service Licensee 23a. Part. Enter the disease or complications that coused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory errest, shock, or heart failure. List only one cause on each line. 6009 HARFORD RD BALTO, MD 21214 Approximete Interval Between Onset and Death aortic aneurysm 30 Immediate Cause (Finet Exsanguination disease or condition resulting in deeth) Sequentielly list conditions, if any, teeding to immediate cause. Enter Underlying Cause (Disease or thjury that initiated events resulting in death) Lest Due to (or es a consequence of): Dua to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpetient 3 DOA 28e. Dete of tnjury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending 1 ☐ Yes 2 ☐ No investigetion

and Box 68760. 980 Division of Vital Records, P.O. certificate or Attending Physician: After death. Director: / within 24 hours after de To the Funeral Directo completely filled in by th Hospital

Physician/Medical þ Completed Be Certification: To

**Physician** 

/Medical

Examiner

Director

Funeral

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Director

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"natural", or itsems 23a

Pages 1 and 2 should be filled within 72 hours a nent of Health and Mantai Hygiene. Int: If Nem 27 is marked other than "natural", o

Department of Health a Important: If Item 27 is any injury or other trax

**Physician** 

/Medical

Examiner

Baltimore, Maryland 21215-0020

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medicat axeminer? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 6 ☐ Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

29a. Certifier (Check only one)

edical

Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the ceuse(s) end menner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signal yra and titla of certifiar Who & Sambele

M.D

29c. Licensa number 043936 29d, Data signed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
THOMAS F. LANSDALE III, M.D. GSGS N. Charles St., Baltimore, MD

State Registrar

31. Date filed (Mach Gay, Year) 1999

32. Registrer's Signeture

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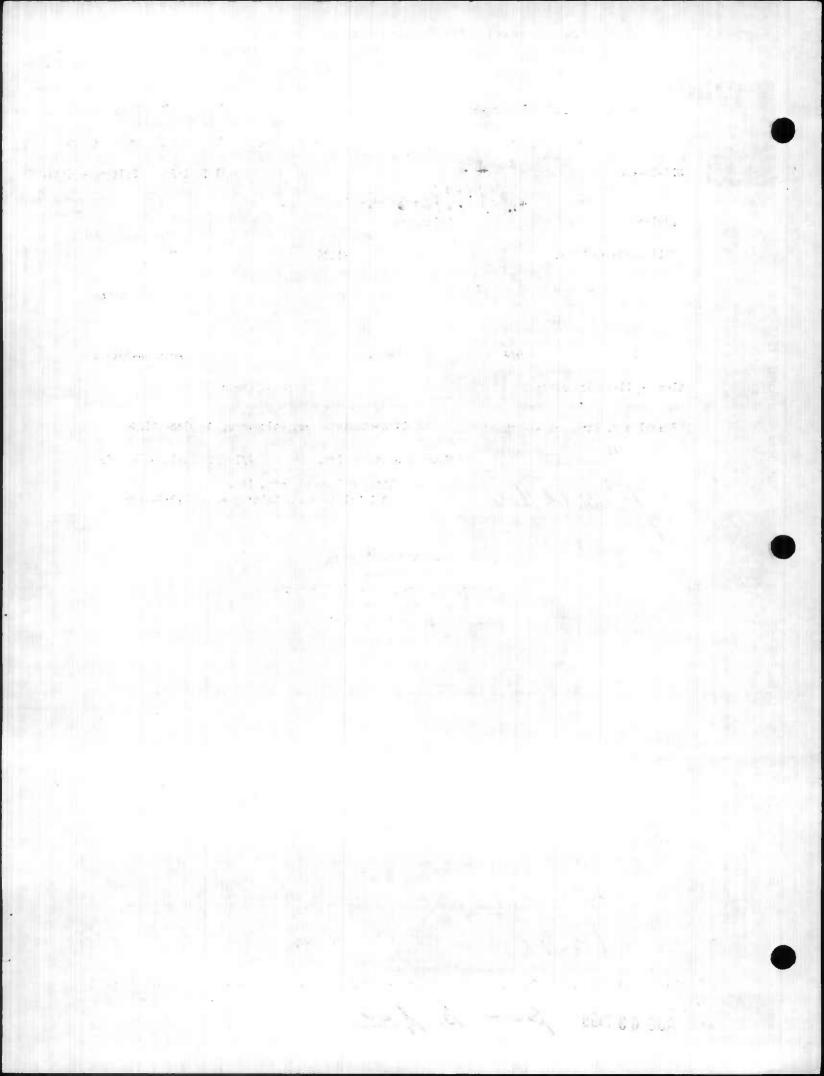
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State of Maryland / Department of Health and Mental Hygiene Q Q 21. 2 = 1

Department or result and Mortial hygeria.  Department or result and Mortial Hygeria.  Department of the marked other than "natural", or items 23s or 23s-f show and important: if item 27 is marked other than "natural", or items 23s or 23s-f show and important or an impor	Gera  4a Facility Nam  3314  5. Social Securit 219-28-98  Usual Restdence 10a. State  Maryland  10e. Street and 3314 Nor  11. Marital Statu 1 Never M 3 Widowe  (S  Elementary/S 17. Father's Nar	e of Decedent  10b. County  Number  thway Drive  is arried 21 Married d  4 Divorced  15. Decedent's Edupecify only highest grade econdary (0-12)	Strempek  street and number)  Drive  7. Age  7. Age  7. Age  12. Was Decedent E  Armed Forces?  1 Yes, Give  Year, Or Dates:	(In yrs. last b 66 10c. City, To Baltin ver in U.S.	Yrs. More more 10 13. Was E If Yes,	f. Zip Code 2123	Hours Min.	8. Date of Birth (Month, Day, April 1,	Day You 17 199 4c. County of Baltimo Year) 1933 Ba	Death  Dre City  Birthplace (State or Fo Country)  Itimore City,  10d. Inside City Li  1X Yes 2	
Examiner Funeral Director	4a Facility Nam  3314 5. Social Securit 219-28-98 Usuai Residence 10a. State Maryland 10e. Street and 3314 Nov 11. Marital State 1 Never M 3 Widowe (S) Eiementary/S 17. Father's Nam	Northway Dy Number 6. Se 15. Decedent's Edupecify only highest grade econdary (0-12)	street and number)  Prive  7. Age  7. Age  12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	(In yrs. last b 66 10c. City, To Baltin ver in U.S.	Yrs. More more 10 13. Was E If Yes,	nths Days	Baltimore If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, April 1,	4c. County of Baltimo Year) 1933 Ba	Death  Dre City  Birthplace (State or Fo Country)  Itimore City,  10d. Inside City Li  1X Yes 2	
Funeral Director	3314 5. Social Securit 219-28-98 Usuai Residence 10a. State Maryland 10e. Street and 3314 Nov 11. Marital State 1 Never M 3 Widowe (S Eiementary/S 17. Father's Nar	Northway D y Number 6. Se 169 15 e of Decedent 10b. County  Number 1	7. Age 7. Age 7. Age 7. Age 7. Age 7. Age 7. Age 7. Age 7. Age 7. Age	66  10c. City, To  Baltil	Yrs. More more 10 13. Was E If Yes,	nths Days	Baltimore If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, April 1,	Baltimo Year) 1933 Ba	Dre City  Birthplace (State or Fo Country)  Itimore City,  10d. Inside City Li  1X Yes 2	
Director	5. Social Securit 219-28-98 Usuai Residence 10a. State Maryland 10e. Street and 3314 Nor 11. Marital Statu 1 Never M 3 Widowe (S) Elementary/S 17. Father's Nar	y Number 6. Se 109 10b. County  Number 10b. County  Number 11bway Drive 1s 1sarried 21 Married 15. Decedent's Edupecify only highest grade	7. Age 7.	66  10c. City, To  Baltil	Yrs. More more 10 13. Was E If Yes,	nths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, April 1,	Year) 9 1933 Ba	Birthplace (State or For Country) Itimore City, 10d. Inside City Li 1X Yes 2	
irector	Usuai Residence 10a. State  Maryland 10e. Street and 3314 Nor 11. Marital Statu 1 Never M 3 Widowe (S) Elementary/S 17. Father's Nar	e of Decedent  10b. County  Number  thway Drive  is arried 21 Married d  4 Divorced  15. Decedent's Edupecify only highest grade econdary (0-12)	12. Was Decedent E Armed Forces? 1 Yes, Give Year or Dates:	66  10c. City, To  Baltil	Yrs. More more 10 13. Was E If Yes,	nths Days	Hours Min.	April 1,	1933  Ba	10d. Inside City Li 1X Yes 2	
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in marked other than "natural", or items 23s or 25s unaute avant, the Medical Examiner must be not To Be Completed by Funeral Direct	3 Widowe  (S  Eiementary/S  10  17. Father's Nar	thway Drive  Is larried 2 Married d 4 Divorced  15. Decedent's Edupecify only highest grade econdary (0-12)	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		13. Was E	2123	4	1		it Country?	
marked other than "natural", or itama 23a o umatic avant, the Medical Examiner must be To Be Completed by Funeral D	3 Widowe  (S  Eiementary/S  10  17. Father's Nar	arried 2 Married d 4 Divorced  15. Decedent's Edu pecify only highest grad econdary (0-12)	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:				34				
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marked other than "umatic avant, the Mer. To Be Comple	17. Fathers Nar	econdary (0-12)		16	ia. Decedent's	Usual Occu	pation during most of wor	kina	16b. Kind of Busin	ess/Industry	
marked other thumatic avant, the	17. Fathers Nar		College (1-4or 5-	+)	(Give kind of work done during most of working life. DO NOT use ratired)			9	Auction-Antiques		
marked out	17. Fathers Nar		10 N/A			er	Laurenne				
marks umatic	timer wil	ne (First, Middle, Last)						e (First, Middle, I	Aaiden Sumame)		
EE		11am Schweige	r				Mary S				
	19a. fnformant's	Name/Retationship (T)	ype, Print)				et and Number or Ru				
m 27 her t		M. Strempek	- Husband	20h Dia-	3314 Nor	thway D	rive, Balti				
r its	20a. Method of I	Disposition 2XXCremation 3 □F	Removal from State		of Disposition tery, crematory			Date	20c. Location - Cit	y or Town, State	
ury ury		n 5 ☐ Other (Specify)		Metro	Cremato	ry, Inc		7/19/99	Baltimore,	MD	
Important: If its any injury or of one	21. Signature of	June al Service Licens	1/		22. Nan Lass	ne and Addr	ess of Facility eral Home,	Inc.			
12.40	7401 Belair Road, Baltimore, MD 21236-4625										
ysician Medical aminer	Immediate Cau disease or cond resulting in deal	lition	a. Cardi	iopulmo	onary A	rrest				Intervat Betwee	
ē l						-	Pressure			i	
amline	Sequentially list	conditions	b		a consequence		rressure				
EX EX	if any, teading to cause. Enter U	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events  Due to					age				
to by the ettending physician and letached for use as the buriel-transit Physician/Medical Examiner		or injury ents h) Last	d	Oue to (or as a	a consequence	of):					
sici	Part ff. Other slg	mificant conditions cor	ntributing to death bu	t not resulting	in the underly	ring ceuse g	iven In Part I.	23b. Did to	bacco use contri	ibute to the cause of d	
igned by the be detach								1 🗆 Y	es 2X No 3	Probably 4 Un	
2 should								24a. Was a perform		24b. Were autopsy find available prior to completion of caus of death?	
director, page								1 🗆 Y	s 2 No	1□Yes 2□No	
certificate rector, pag	25. Was cese re	eferred to medical					26. Place of Dea	th (Check only or	е)		
this cel direction of the cel	examiner?	X No F	Hospitai: 1 ☐ Inpatier	nt 2 ER/0	Outpatient 3[	DOA O	ther: 4 Nursing H	ome 5 Reside	ence 6 Other	(Specify)	
- 9	27. Manner of D		28a. Date of Injury (Month, Day	Year) 28b	. Time of fnjury	28c. fnje	ury at ork?	28d. Describe h	ow Injury occurred		
To the Funeral Director: After the completely filled in by the funeral Medical Certification:	2 Accider 3 Suicide	2 Accident Investigation			M 1 ☐ Yes 2 ☐ No 28f. Location			28f. Location (S	on (Street and Number or Rural Route Numbe Town, State)		
filled in	29a. Certifier		alcian: To the best of		ge, death occu	irred at the t	ime date and place			er as stated.	
he Funer pletely fill edical	(Check only one)	2 Medical Exami	inar: On the basis of and manner stat	examination a	and/or investig	ation, in my	opinion, death occu	rred at the time, d	ate and place, and	due to the cause(s)	
Me Me	29b. Signature a	ing the gloentiter 7	17 528			29c. Licer	nse number	2	9d. Date signed (/	Month, Day, Year)	
0	<b>&gt;</b> 1	1/ 9 M	1			D3	0060		7/27	MI	
	30. Name and a	ddress of person who co	ompleted cause of de	ath (Item 23s	) (Type Print)						
		d Davis, M.					rite 403	Raltimos	CA MD	21204	
State		fonth, Day, Year)	32. Registra			,			- , .w z		

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Records. Division of Vitai

The law requires that the death certificate be executed certificata or Attanding Physician: this After s after death.

Be Completed

edical Certification: To

25. Wes case referred to medical 1 Yes 2 No 27. Menner of Death 1 Netural

5 Pending 2 Accident 3 Suicide 4 Homicide

invastigetion 6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28a. Dete of Injury (Month, Day Year) July 29, 1999 12:15

Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of Home 28c. Injury at Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

26. Place of Death (Check only one)

10 foot fall off ladder/scaffolding

28f. Location (Street and Number or Rural Route Number, City or Town, State) 925 Maldon Road, Battimore, MD

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the bests of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner steted. 29e. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. License number

tillon oun

PAS # 08761

YIUL

Baltimore, MD.

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

M.D FITTON, 31. Date filed (Month, Day, Year) AUG 0 3 1999

32. Regigner's Sig

Sinai pospital of Baltimore

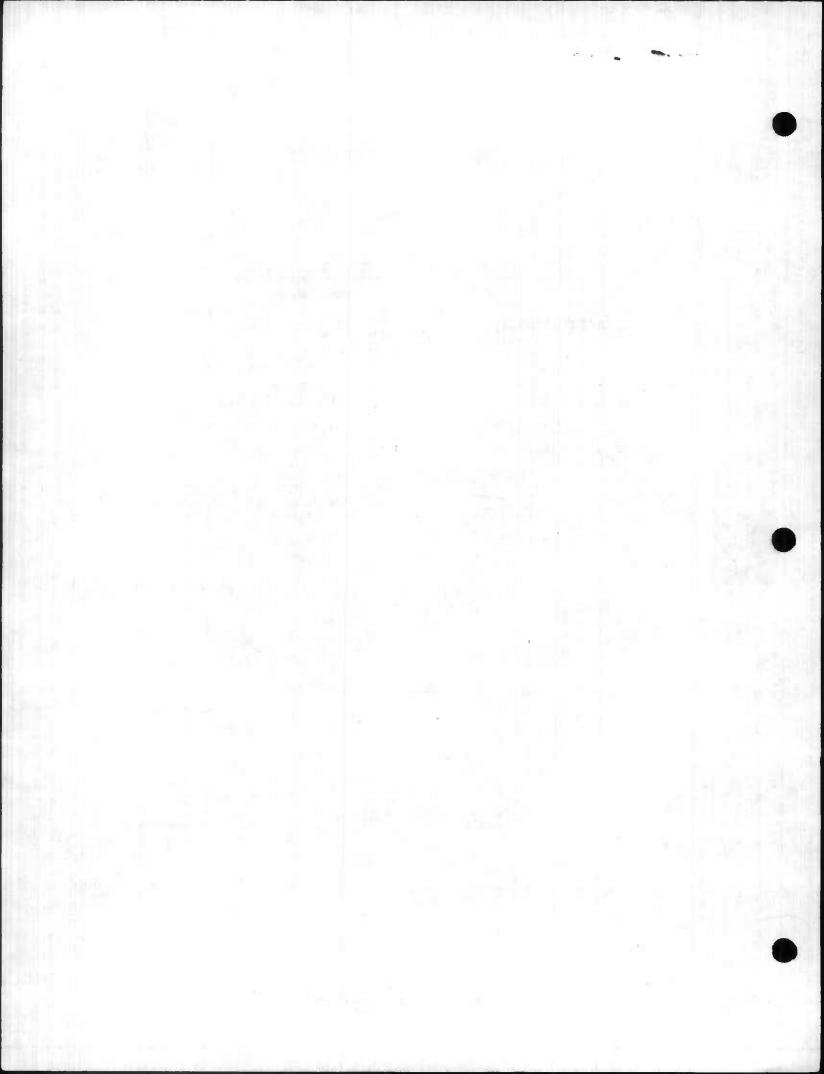
State Registrar

DHMH 16 Rev 6/95

24 hours a Hospital

within 2 \$

completely



		State of Marylan		artment of I			giene g	9	24253
	1. Decedent's Name (First, Middle, Las	3t)				2. Dete of Dea	_		3. Time of Deeth
in al		ohn Sfakianos	5	1	4h City Tourn or	Month July	Day 31 1	Year 999	6:QOPM
er						Location of Death			
	6 Elphin Cou			Williams 4 Wass	Timonium			imor	
	5. Sociel Security Number 6. Sociel Security Number 1 212-22-1269  Usual Residence of Decedent	ex 7. Age (In yrs. 1	last birthdey) Yrs.	If Under 1 Year Months Days			, Year)		plece (Stete or Foreign ntry) York
	10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				T	10d. Inside City Limits
Be Completed by Funeral Director	MD. Baltimor	e Tir	monium						1 ☐ Yes 2 ☐ No
ត់	Toe. Street and Number			10f. Zip Code			log. Citizen of V	What Cou	ntry?
<u>a</u>	6 Elphin Court	#202		2109	93		Ü	ISA	
ne	11. Maritel Status	12. Was Decedent Ever in U, Armed Forces?	S. 13.	Was Decedent of I	Hispenic Origin? (	Specify Yes or No- rto Rican, etc.)	14. Rac		can Indien,
F	1 ☐ Never Married 2 ☑ Married	1 StYes 2 □ No				no nican, etc.)	Bled	k, White,	etc.
ď	3 Widowed 4 Divorced	If Yes, Give WW] Year or Detes:	ΓŢ	1 ☐ Yes 2 🔀 No	Specify:		Specify	" Wh	ite
ed	15. Decadent's Ed	ucation	16a Decer	dent's Usuel Occup	netion		16b. Kind of Bu		
let	(Specify only highest gree	de completed)	(Give	kind of work done DO NOT use retire	during most of wo	orking	105.11.10.01.51	30111000311	dony
Ē	Eiementary/Secondary (0-12)	College (1-4or 5+)				,	11 a C D 1		
ပိ	47 Eshada Nama (Casa Middle Casa)	+4	Direc	ctor Of I			H&S Bak		
Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,	Maiden Sumen	10)	
T <sub>0</sub>	John Nicholas Sfa	kianos			Germain	n Girard			
•	19a. Informant's Name/Reletionship (7	ype, Print)	19b. Mailir	ng Address (Street	and Number or F	iurel Route Numbe	r, City or Town,	State, Zij	Code)
	Mrs. Despo P. Sfak	ianos	6 El	phin Cour	ct #202 5	rimonium,	MD, 21	.093	
	20e. Method of Disposition	20b. P	laca of Dispo	sition (Name of		Dete	20c. Location -	City or T	num State
	1 ⊊ Burial 2 ☐ Cremation 3 ☐	Removal from State	emetery, crer	metory or other ple	· ·	50.0			
	4 ☐ Donation 5 ☐ Other (Specify	) Dula	aney Va	alley Cer	netery	8-3-99	Timoniu	m, M	D,
	21. Signature of Funitral Service Licent	100 / /)	22	2. Name end Addre	ess of Facility				
	101/1/2	A. your		Ruck To	owson Fur	neral Hom	e, Inc.		
_	11107	0 //-		1050 Yo	ork Rd. S	rowson, M	D. 2120	14	
	23a. Pertt. Enter the disease of comp shock, or heart failure. It only o	ilicetions that/caused the deeth one ceuse did each line.	n. Do not ent	er the mode of dyi	ng, such es cardia	ac or respiratory en	est,		Approximete Interval Between
	150							-	Onset and Death
	Immediate Cause (Finel disease or condition	· Prostate	( 0	0000					
	resulting in death)	***************************************	r es a conseo						
er		200 (0 (0	os a consec	quarica or).				1	
Examiner		b		9				1	
Xa	Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying	Due to (or	r as a conseq	quenca of):				į	
calE	cause. Enter Underlying Cause (Disease or Injury	C							
	that initiated events resulting in deeth) Last	Due to (or	es e conseq	uence of):				i	
Completed by Physiclan/Med								1	
5	_	d						-	
2	Port II Other elections conditions on	madhuda an darah hua an an	dale e de abecom	- 4- 4-4	and David	ant Dist			
IXS	Pert II. Other eignificent conditions co	ntributing to death but not rest	itting in the ui	ndenying cause gr	ven in Pert I.	23b. Did to		ntribute t	o the cause of death?
۵						1 U Y	ee 2 No	3 Pro	bably 4 Tunknown
ğ									
g						24e. Was a	in autopsy med?	24b. W	ere eutopsy findings relieble prior to
ble								of	mpletion of cause death?
Ĕ							/		
ŏ						1 U Y	es 2 No	11	☐ Yes 2☐ No
Be	25. Was case referred to medical exeminer?			1 -		eath (Check only or	ne)		
Lo	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpetien	nt 3 DOA	ner: 4 Nursing	Home 5 D Resid	ence 6 Oth	er (Speci	(y)
5	27. Manner of Deeth	28e. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju Wo	ry at	28d. Describe h	ow injury occurr	red	
atic	1 Maturel 5 ☐ Pending 2 ☐ Accident investigation		in july		Yes 2 □ No				
#IC	3 ☐ Sulcide 6 ☐ Could not be determined	286. Place of injury - At no	me, farm, str	eet, factory, office		28f. Location (S	treet end Numb	er or Rur	al Route Number,
ert	4 Homicide	building, etc. (Specify	)			City or Tow	n, Stete)		
Ŭ	20. 0. 19.	-							
ca	(Uneck only 2 Medical Exam	raician: To the best of my know iner: On the basis of examinat	vledge, death ion end/or Inv	n occurred at the til	me, dete and plac	e, and due to the c	ause(s) end me	nner as s	stated.
Medical Certification:	one)	and menner stated.					uno prace, i		- 1.10 00000(0)
Σ	29b. Signeture end title of certifier			29c. Licens	se number	2	9d. Date signe	d (Month,	Dey, Yeer)
	) Chun Ho	theor mo		NOU	5385	7-	8/7/	99	
					0000	4	0/41	11	
	30. Name end address of person who c	4 4	23e) (Type,	Print)	100 11	21.6		- 7.	1000
	some Hobican a	ncology Cent	ur, 60	N. Wa	MAG ST.	Baltin	none, V	WD	21201
e	31. Dete filed (Month, Day, Year)	32. Registrar's Signal		1					

Stat Registrar

Physicia /Medic Examin

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiere. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Medical Examiner must be notified another.

Physician /Medical **Examiner** 

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

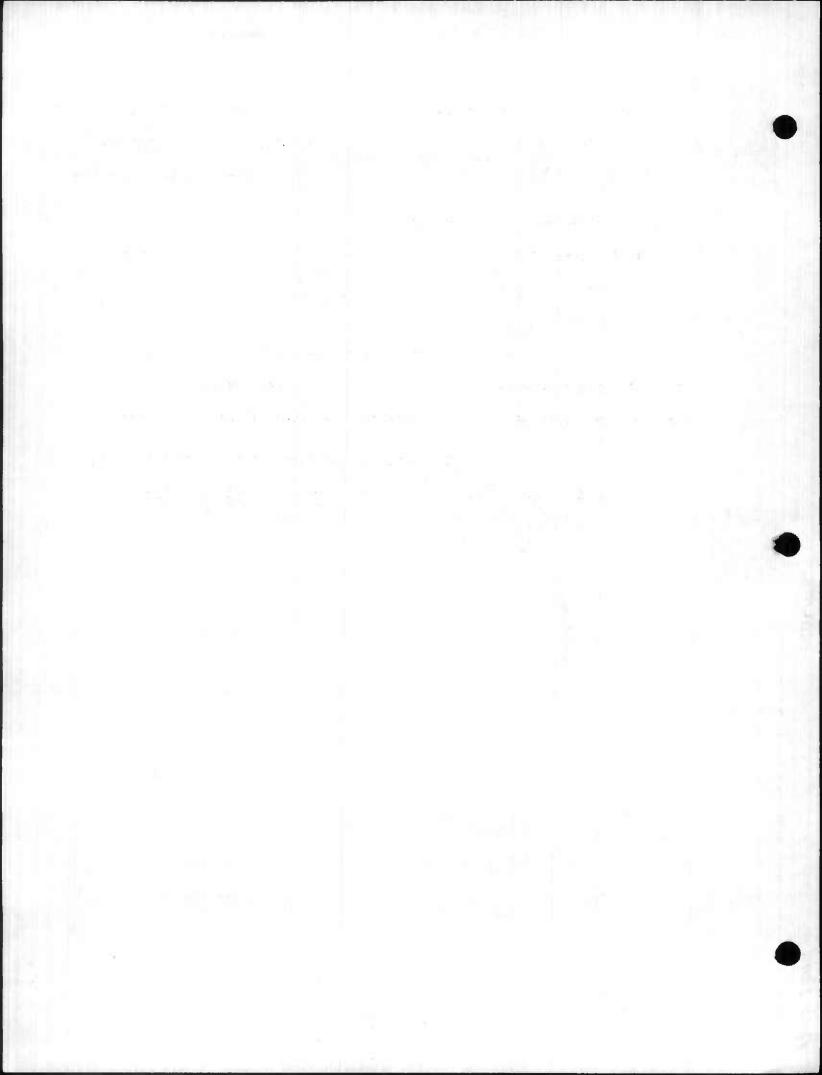
To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

AUG 0 3 1999

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Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

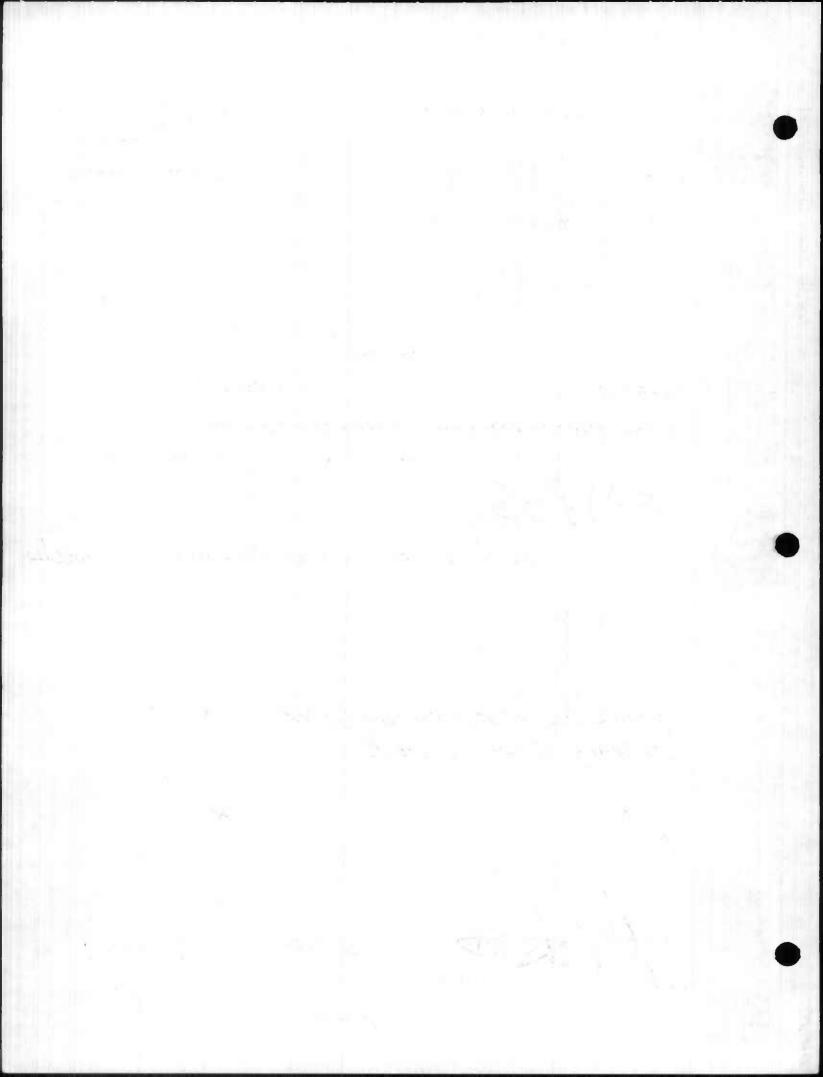
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State of Maryland / Department of Health and Mental Hygiene

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Dhoolala		1. Decedent's Name	(First, Middle	a, Last)								2. Date of D	eath	Van	3. Time of Death
Physicia /Medic		Amelia	a San	dra	Sier	kiele	wski					July 3	30, <sup>Dey</sup> 1999	Year	11:30 AM
Examin	- 0	4e. Facility Name (If I								4b.	City, Town, or Lo	ocation of Dee	th 4c. Cour	nty of Deat	th
		1 Lochmoor C	court							Lu	utherville		Balt	imore	Co.
Funeral Director		5. Social Security Nut 213-32-590	68	6. Sex	M 2□XF		yrs. last bir		If Under 1 Yes Months Dey		f Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D Feb.	ay, Year)	9. Birt Co Ma	thplace (State or Foraign buntry) aryland
how		Usuel Residence of D 10e. State	Decedent 10b. County			100	. City, Tow	n or Loca	ation						10d. Inside City Limits
Ma F	ctor	Maryland	Baltim	ore (	Ò.		Luther	ville	9						1 ☐ Yes 2 ☒ No
\$ 28	Sire.	10e. Street and Numb	ber						10f. Zip Code	9			10g. Citizen o	f What Co	ountry?
23a	a	1 Lochmoor C	court						2109	93				USA	
r dea	Funeral Director	11. Marital Stetus		12	Armed Fo	edent Ever	In U,S.	13. We	es Decedent of	f Hisp	anic Origin? (Spo Mexican, Puerto	ecify Yes or N	o- 14. R	ace - Ame	ricen Indien,
urs e	by	1 ☐ Never Married 3 ☐ Widowed 4		led	1 ☐ Yes If Yes, Gi Yeer or D	2 □No			JYes 2⊠N		Spacify:	· · · · · · · · · · · · · · · · · · ·	Spec	-i6	nite
72 ho	eted	(Specifi	15. Decedent y only highas	's Educa	tion		16a.	Deceder (Give ki	nt's Usual Occ	cupation	on	ina	16b. Kind of	Business/	Industry
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Hyg offier ont,	Be C	17. Father's Neme (F	irst, Middla,	Last)			-	TOIRCI	ICITOL	18	8. Mother's Name	(First, Middle		-	
lental kad (	0	Samuel Se	rio								Josephi	ne Ser	io		
should be	-	19a. Informent's Nerr	ne/Relationsi	hip (Type	, Print)		19b	. Mailing	Address (Stre	et and	d Number or Run	al Routa Numi	ber, City or Tow	m, Stata, 2	Zip Coda)
end 2 palith 27 is		Mr. Ramon	Sienk	ciele	wski.	/Husba	and I	Loc	chmoor	Cot	irt Luth	ervill	e, MD,	21093	3
of He		20a. Method of Dispo	sition			20	b. Place of	Disposit	ion (Nama of tory or other p		T	Date	20c. Location	1 - City or	Town, State
Peg ment ant: I		1 Burial 2 4 Donation 5			novei from		loodla	awn (	Cemeter	У	8	-2-99	Woodla	wn, 1	MD.
permit. Departimporti		21. Signature of Fund	eral Service I	Bansoo		7		22. 1	Name and Add	dress			Funeral d. Towso		
		23a. Pert1. Enter the shock, or heart	disulse, of	complice	Mons that o	aused the c	death. Dor	not enter	the mode of d	lying,	such as cerdiec o	or respiratory a	arrest,		Approximate
Physician /Medical Examiner		Immediate Ceuse (Fi disease or condition resulting in death)	inal			ASTA 1	11 (	ARC	INOM		of Th			1	Interval Between Onsei end Death
	Je.					Due	to (or es a	conseque	ence or):					l	
cate be executed physician end s the bunal-transit	Examiner	Sequentially list cond	ditions,	b		Due t	o (or as a	conseque	ence of):						
e be es rsician e buria	edicai E	Sequentially list cond if eny, leading to imm cause. Enter Underly Cause (Disease or In that Initiated events	/ing jury	c		Due	o (or es a c		non of\						
entificat Jing phy se es th	8	resulting in death) La	st	ال ا		Due (	o (or es a c	onseque	nce or).						
eath cert ettending	Physician/N			- 0.											
the de	ysic	Pert II. Other significa	ant conditio	1 .		_							4	ontribute	to the causs of death?
igned by	by Ph	Chron	10 O E	OST	ructi	ve f	u/m	ionai	ry DI	St	ise	1/2	Yes 2□ No	3 Pr	robably 4 Unknown
been s	Completed	Coron	ary	Ar	TEX	ZY /	15	Pus	ry Di				s an autopsy ormed?		Were autopsy findings evellable prior to completion of ceuse
Physician: The law this certificete hes al director, page 2	E												Yes 2 No		of deeth?
ifficet	Re C	25. Was case referred	d to medical							2	C Diseas of Death				1 ☐ Yes 2 ☐ No
ysicia s cert direct	0	exeminer?		Hos	spital:	npatient	2 □ ER/Qu	tpatient	3□ DOA	Other:	<ol><li>Place of Deeth</li><li>A   Nursing Ho</li></ol>			ther (Sne	cifu)
ding Ph. After thi funeral	tion:		5 Pending	g	28e. Dete		28b. 1	Fime of njury	28c. Inj	/ork?			how injury occ		uny
To the Hospital or Attanding Physician: within 24 hours efter death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	2 <sup>s</sup> ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	6 Could n determi	not be	28e. Plece buildi	of Injury - Ang, etc. (Sp	At home, fa	rm, stree	t, fectory, offic	_			(Street and Num wn, Stete)	nber or Ru	ural Route Number,
e Hospit n 24 houn e Funera sietely fille	edical	29e. Certifier 1 (Check only one)	Certifying	g Physic Examine	r: On the bi	best of my asis of exam ner stated.	knowledge nination end	, deeth o	ccurred et the stigation, in my	tlme, y opini	dete and plece, of ion, death occurr	end due to the ed et the time,	ceuse(s) and r date and place	nanner as a, and due	stated. to the ceuse(s)
within To th		29b. Signature and to	a of conflige			-			29c. Lice	nse n	umber		29d. Date sign	ed (Monti	h, Dey, Year)
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	1	30. Name and address									1			-	
		Dr. John Mil							Maryland	d 2	21093				
State Registra	-	31. Date filed (Month,	G 0 3	1999	32. 5	egistrar's Si	ignature	9.	Spare	1					

DHMH 16 Rsv 6/95

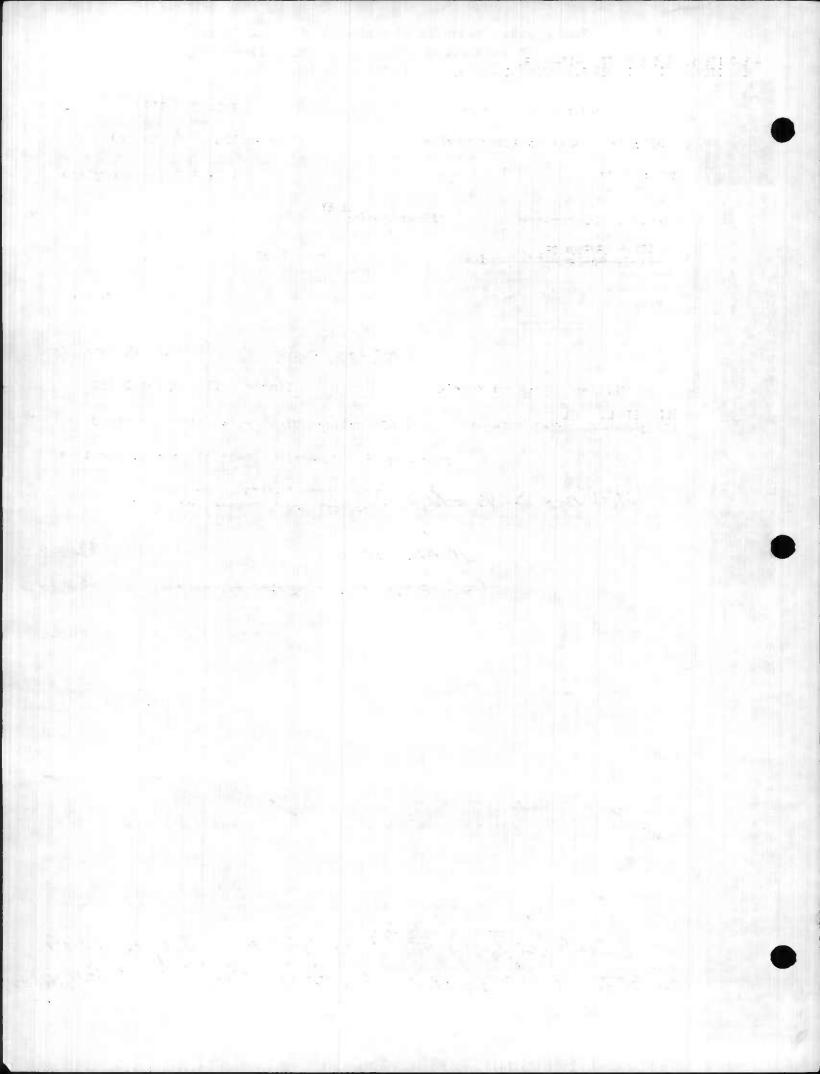


Please Type or Print in Biack indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24255 AMEND ITEMS: #10C.E.F. G775 9-17-99 WR.
AMEND ITEMS: # 19A, 18 PER F.H. G774 8-19-99 WR. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth 1999 Month **Physician** 29, 6:26 AM July Lineta M. Sparks /Medical 4e Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Clarksville Howard Hillside House Assisted Living If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Sociel Security Number If Under 1 Year 7. Age (In yrs. lest birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Months Deys Yrs. Director 227-64-9831 Maryland 100 Usuel Residence of Decedent the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f ahow OLNEY 1 ☐ Yes 2 ☐ No Maryland Silver Spring Directo Montgomery 10e. Sfreef and Number 10f. Zip Code 10g. Citizen of Whet Country? 7 is marked other than "natural", or items 23s or traumatic event, the Medical Examiner must be a 17009 NORBROOK DR 20832 -20902-U. S. A. death Funeral ew Drive <del>11802 College</del> 12. Was Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien Bleck, White, atc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0020 1 Yes 2 No Specify: White by 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h. Kind of Business/Industry Hygiene. filed within Elementary/Secondary (0-12) Coilege (1-4or 5+) Norfolk Naval Yard Fiscal Acct. Clerk 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) . Pages 1 and 2 should be file ment of Health and Mental Hy lant: If item 27 Is marked oth jury or other traumatic event Be Lineta Belle Caplos CAPLES Shepherd Morris 10 William 19e. Informent's Neme/Reletionship (Type, Print) ELISABETH L. BUBEL 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 11802 College View Drive, Silver Spring, Md. 20902 Elizabeth L. Bubel (Niece) altimore, 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Department of Important: If any Injury or 7-31-99 Towson, Maryland Prospect Hill Cemetery 21. Signetura of Funerel Servica Licensee 22. Neme end Address of Fecility Ruck Towson Funeral Home, Inc. Ruck Towson Funeral Home, It 1050 York Road, Towson, Md. 23a. Pentl. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medicai INANITION Examiner Examiner HEMMER physician and the burial-fran Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in deeth) Last Due to (or es a consequença of) Box 68760, certificate be edicai Due to (or es e consequence of): 88 Physician/M esn 50 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.0. signed by t d be detach 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed page 2 s hes 2 10 No 1 Yes 1 Yes 20 NO certificate Division of Vital Attending Physician: 25. Wes case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1 Inpatient 2 ER/Outpetient 3 DOA this 28e. Dete of Injury (Month, Dey Year) funeral 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? After 1 Netural 5 Pending after death. 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, streef, fectory, office building, etc. (Specify) 4 Homicide Hospital or 24 hours a (Decartifying Physician: To the best of my knowledge, death occurred et the time, date and piace, and due to the ceuse(s) and manner as steted. 29a. Certifier Medical Madical Examinar: On the basis of examination end/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29b. Signeture e 29d. Date signed (Month, Day, Year) Uly 30 Name end eddress of person who come ed cause of death (Item 23a) (Type, Print)

246

Registrar

State



State of Many

yland /	Department	of Health and	Mental	Hygiene
	Certificate	of Death		Dea No

-	0	9	21	0	-	1
	)	7	24		7	1

**Physici** /Medic Examin

**Funeral** Director

permit. Peges 1 and 2 should be filed within 72 hours efter death with the Meryland Department of Health and Mentel Hygiene. Important: if fem 27 is marked other than "natural", or items 23 a or 28=f show any injury or other traumatic event, ma Hedical Examiner must be notified at another.

Baltimore, Maryland 21215-0020

Physician /Medical **Examiner** 

To the Hospital or Attending Physician: The law requires that the death certificate be associted within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

<ol> <li>Decedent's Neme (First, Midd</li> </ol>	(12 1 act)					2. Date of D			3. Time of Death
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in parking lot					Baltim		40.000	N/A	
5. Sociel Security Number 218-07-0579	6. Sex 1 → M 2 □ F	7. Age (In yrs. 77			If Under 24 H	Irs. 8. Date of Bi	lay, Year)	9. Birtl	hplace (State or Foreign untry)
Usual Residence of Decedent	Α	, ,				10-0	6-21	P	1D
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17. Father's Neme (First, Middle,	Last)					Name (First, Middle	e, Maiden Sum	ame)	
Joseph	M. Tru	sty			Sara	h	Boulde	en	
19e. Informent's Neme/Relation	ship (Type, Print)		19b. Meilic	ng Address (Street	and Number or	Rural Route Numi	ber, City or Ton	n, State, 2	(ip Code) 21202
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21. Signeture of Funerel Service Licensee				2. Neme and Addre	ss of Facility	Baltimo	re, Ma	ryla	and 21202
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DHMH 16 Rev 6/95

State Registrar 31. Dete filed (Month, Day, Year)

AUG 03 1999

32. Registrar's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death 8355m Bertha Α. Thomas 29, 1999 4c. County of Death 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Stella Maris Hospice @ Mercy NA Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 SC 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 ☐ M 2 ☐ XF Months Days Hours Min Yrs 219-32-9896 62 01-22-37 Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD NA Baltimore XX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 501 E. Preston Street Apt. #105 21202 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 ☐ No Specity: Specify: Black 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent'a Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) NA Self-employed of home 8th Grade in & out 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Frank Code Inez Rice 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant'a Name/Reletionship (Type, Print) 3206 Lake Avenue Baltimore, Maryland 21213 Darnett McDaniel 20b. Place of Disposition (Name of cemetery, crematory or other placa) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Zion Cemetery 08-04-99 Lansdowne, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Baltimore, Maryland 21202 21. Signature of Funerel Pervica Licenses lu WM.C.March FH 1101 E. North Avenue 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death immediate Cause (Finel unknows disease or condition resulting in death) uno Due to (or es a consequence of) LOSUS Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Cause (Disease or injury Due to (or es a consequenca of): that initiated events resulting in death) Last Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 3 □ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopay findings available prior to 24e. Was an autopsy performed? completion of cause of deeth? 1 ☐ Yes 21X No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) STE //A MARIS AT MERC) 25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Haspic 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Date of Injury (Month, Day Year) 27, Menner of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 ☐ Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 - Homicide

P.O. Box 68760, Division of Vital Records,

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**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

**Funeral** 

**Director** 

permit. Pages 1 and 2 should be filed within 72 hours after death with the Man/land Department of Health and Mental Physiene. Important: If Itam 27 is marked other than "natural", or items 23a or 28a-f ahow any Injury or other traumetic event, an Medical Examiner must be notified at

**Physician** /Medical

Examiner

Examiner

Physician/Medical

by

Completed

To

Certification:

edical

29a. Certifier

(Check only one)

Baltimore, Maryland 21215-0020

State Registrar 03

29b. Signature and title of certifier

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) 1999

10

32. Registrar's Signature

St

Jercertifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) and manner as ateted.

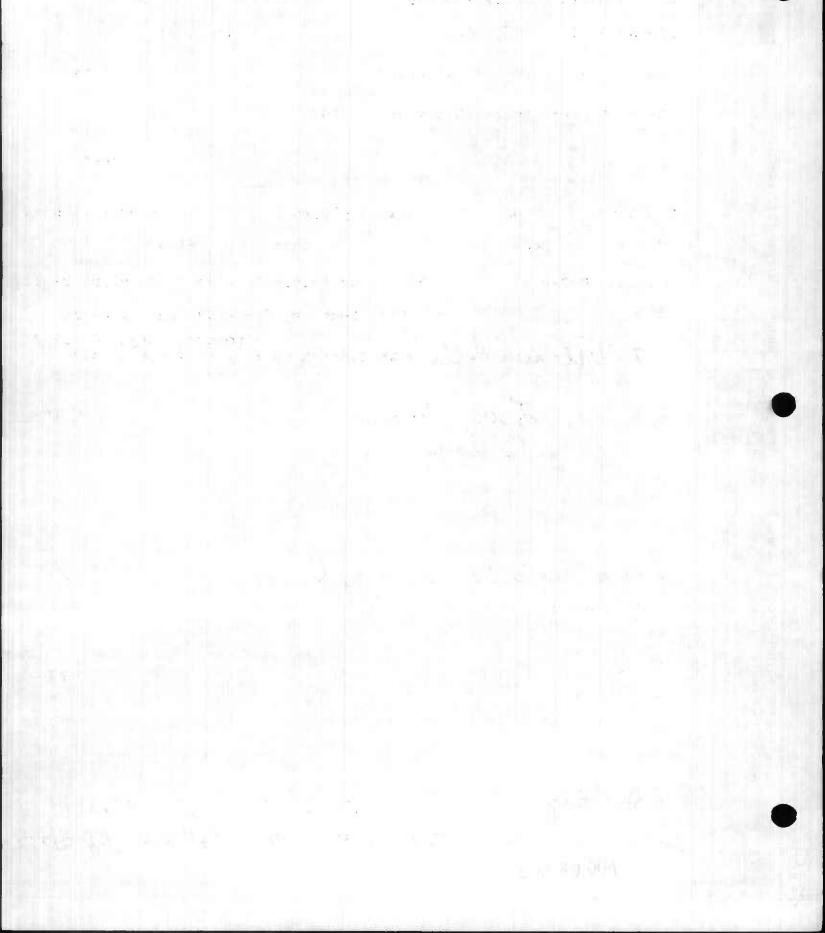
2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

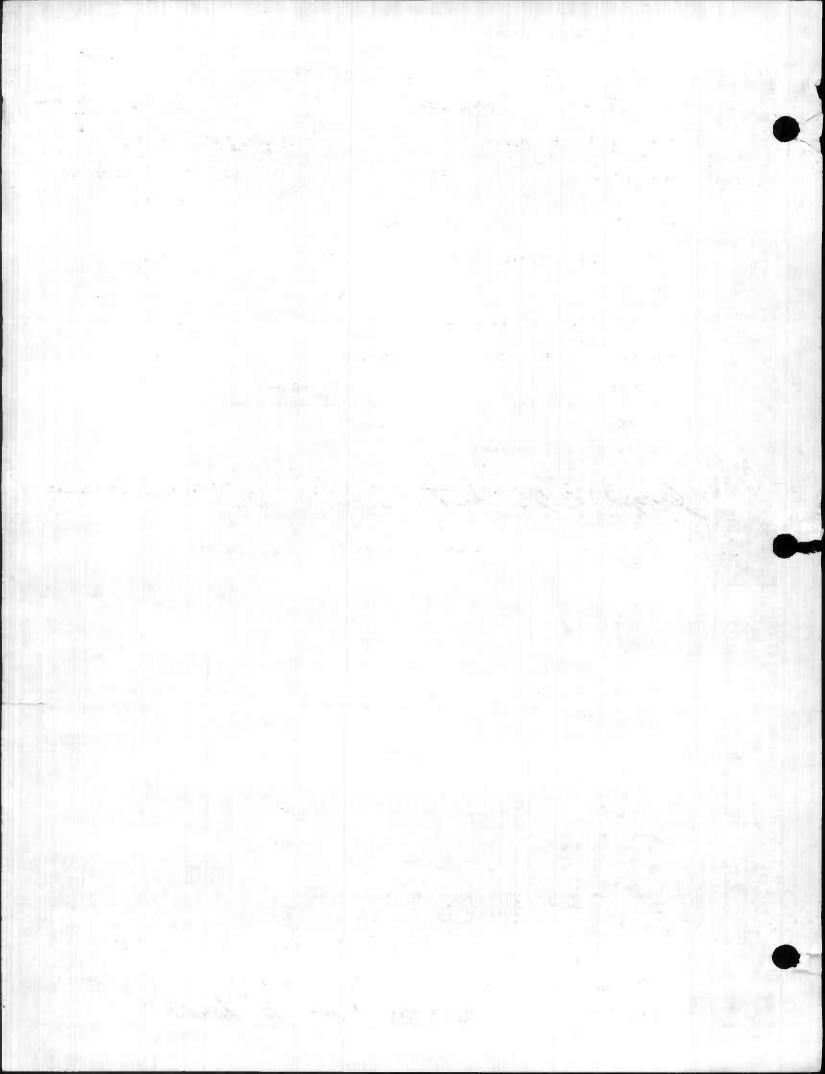
BAHIMORE, MD 21202

**DHMH 16 Rev 6/95** 



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/Medical Examiner	4a Facility Nama (If not in				UZ		4	b. City, Town, or I	ocation of Deat		99 of Death	/   //
	Frankford	Nursin	g Home					Baltimo				
uneral rector	5. Social Security Number 217–26–936	11	8x 7.	Aga (In yrs.	last birthday) 8 Yrs.	If Unde Months	Days	If Undar 24 Hrs. Hours Min.	(Month, Da	th ly, Year) 15,1931		aca (State or Fo ry) Land
	Usual Rasidanca of Dece			1								
M H	10a. Stata 10b.	County		10c. Cit	ty, Town or Lo	cation					10	d. Inside City L
or items 23e or 25e-f show miner must be notified at Puneral Director	Maryland			В	altimo:	re						1 X Yas 2
be notified Director	10e. Street and Number					T	p Coda			10g. Citizen of V	Vhat Count	ry?
0 2		ford A					11206			** 0		
r Items 23. blosc must Furneral	11. Marital Status	TOLU A	12. Was Deceda	nt Ever in U	S 13 1		21206	ispanic Origin? (S	pecify Yaa or No	U.S.	A . e - Amarica	an Indian.
La Par	11. Marital Status		Armed Force	is?		f Yas, sp	cify Cuba	n, Maxican, Puart	o Rican, atc.)		k, Whita, a	
	1 Navar Married 2		1 ☐ Yas 2] If Yes, Giva			1 🗆 Yas	2 No	Spacify:		Specify	: bla	ick
d b	3 ☐ Widowed 4 ☐ □	vorced	Year or Date	s:								
disa disa	15. D (Specify on	ecedent's Ed	ucation da com <i>platad)</i>		16a. Deced	dant'a Usi	al Occupa	ation du <i>ring</i> most of wor	kina	16b. Kind of Bu	sinass/Ind	ustry
A di	Elamantary/Secondary		College (1-4	or 5+)	lifa. l	DO NOT	use retired	)				
rt, the Medical is Completed	unknown		nknown		uı	nknov	m_			unkn	own	
avent, Be C	17. Fether'a Name (First,	Viddle, Last)						18. Mothar's Nan	na (First, Middla	, Maiden Surnem		
	unknown							unknown				
marked martic e		slationable /*	Tuna Drine)		10h Mante	no Addres	o /Chroat	end Number or Ru	ral Route Muse h	or City or Tour	State 7in	Code)
	19e. Informent's Neme/R	aretronsnip (7	ype, rnnt)					and ivamber or Hu	rai nouta Numb	or, ony or rown,	Stete, ZIP	0000/
other to	unknown					nknov						
= 5	20a. Mathod of Dispositio  1 Burial 2 Crai  4 Donation 5 0	nation 3 🗆		ita	Place of Dispo cematary, crar			(6)	Data	20c. Location -	City or To	wn, Stata
Important: any injury once.	21. Signature of Funaral O	seph B		ng -	f St	tate	Anat	ss of Facility omy Boar		W. Balti	more	Street
	23a. Part I. Enter the disc	12)	non-0	21				MD 212				
miner	disease or condition resulting in death)		eb.		or es e consec			Acc			1	
hysician and the burishransit dical Examiner	Sequentially list condition if eny, laeding to immadia causa. Entar Undarlying Cause (Disass or injury that initieted events	s, ta		Due to (d	or as a consec	quenca of	):					
s by the attending physicial stached for use as the bur Physician/Medical	resulting in deeth) Last	J	d	Dua to (c	or as a conseq	juance of	:					
for u												
hed hed	Part II. Other significant	onditions co	ontributing to deat	h but not ras	ulting in tha u	ndarlying	causa givi	an in Part I.	23b. Did	tobacco uae co	ntribute to	the cause of d
9 0	I	emc	nha						10	Yes 2□ No	3 Prob	abfy 4 Duri
should should leted										an autopsy ormed?	ava	ira autopsy findi iilabla prior 10 npletion of caus leath?
page 2									1□	Yas 2 D(No	1	Yas 2□ No
	OF Was seen referred to											7140 20110
E SE	25. Was casa rafarrad to axeminer?	-	Hospital:				Oth	26. Plece of Dec				
# 5		Pandino	28e. Dete of (Month,		28b. Time of Injury	f	28c. Injun Worl	4 La rivursing F	-	idence 8 D0th how injury occur		1)
55 %	2 Accident 3 Suicide 6	invastigation Could not be				М		100 2 110	001 1	(0		I David M.
or: Al the fu		datamined	28a. Place of building	Injury - At h atc. (Specil	oma, farm, str	reet, facto	ry, office		28f. Location ( City or To	(Street and Numb wn, Stata)	er or Rura	l Route Number
in by the artifical	4 Homicida			st of my kno				na, data and place				
Funeral Director: All intrody filled in by the fundational Certification	29a. Cartifier 11		ysicfan: To tha be ifner: On tha besi and mannai	s of axamine	HIOH ANGUOI III	vastigotio						tria causa(s)
o the Funeral Director: All ompletely filled in by the fu Medical Certification	29a. Cartifier 1 (Check only 2 )	edical Exam	fner: On the besi	s of axamine stated.	7		9c. Licans				d (Month, I	
pletoly fill edical	29a. Cartifier 1 (Check only one)	edical Exam	fner: On the besi	s of axamine stated.	7		9c. Licansi				d (Month, I	
To the Funeral birector: All completely filled in by the funeral Medical Certification	29a. Cartifier 1 (Check only one)	edical Exam	fner: On the besi	s of axamine stated.	7		D 4				d (Month, I	

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. State of Maryland / Department of F	lealth and Menta	I Hygiene 99	ble. 24259
		Reg. No.	3. Time of Death
1. Decedent's Neme (First, Middle, Last)	Mod	onth Dey	Year / /
VAlAida J. Taylor	JU	27 37	999 1.40 AM
	4b. City, Town, or Location of BALTIMOR		of Death
GOOD SAMARITAN HOSPITAL  5 Social Security Number 6 Sex 7 Ana (In use lest hirthday) If Under 1 Year			NH (State on Familia)
5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) If Under 1 Year Yrs. Months Deys	Hours Min. (Mo	te of Birth onth, Day, Year)	9. Birthplace (State or Foreign Country)
Usual Residence of Decedent	rek	15,1933	467
10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
mb NA Baltimore			1 Yes 2 □ No
10e. Street and Number		10g. Citizen of W	What Country?
	265	US A	
	tispanic Orlgin? (Specify Ye		e - American Indian,
Armed Forces? If Yes, specify Cube	en, Mexican, Puerto Rican, e	etc.) Black	k, White, etc.
1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	Specify:	Specity:	Black
15. Decedent's Education 16a. Decedent's Usual Occup (Specify only highest grade completed) (Give kind of work done)	during most of working	16b. Kind of Bu	isiness/industry
Elementary/Secondary (0-12)  College (1-4or 5+)  Home man	d)	74	Home
17. Father's Name (First, Middle, Last)	18. Mother's Name (First,	Middle, Maiden Sumam	e)
Freder C. Santa Sp	mas. N	20015	
19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street	and Number or Rural Route	Number, City or Town,	State, Zip Code)
1 0 1 1 - 0 0 10	ech O m2	S. Ito M.	10 CIC. 1
20a. Method of Disposition  1 MBuriel 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)	- Delebour 8-6-		City or Town, State
1 Sugar 15 Stams 4300 W	use facility where Aborabash Are.	Le West I	NC. 21215
23a. Part I Enter the drause, or complications that caused the death. Do not enter the mode of dyin shock, or heart failure. List only one cause on each line.  Immediate Cause (Final		atory errest,	Approximete Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)  a. MYOCARDIAL INF.	ARCTION		
Due to (or as a consequence of):			
VOLUME OVERL	OAD		
Sequentially list conditions,  Due to (or as a consequence of):			
if any, leading to immediate cause. Enter Underlying END STAGE REN	VAL DISEA	SE	•
Cause (Disease or Injury that Initiated events resulting In death) Last  Due to (or es e consequence of):			
d. DIABETES MEL	-LITUS		
Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause give	ven in Part I. 23	3b. Did tobacco uae cor	ntributa to the cause of deeth?
SEPSIS		1 Yes 2 No	3 Probably 4 Unknown
	24	a. Was an autopsy	24b. Were autopsy findings

**Physician** /Medical Examiner

To the Hospital or Attanding Physician: The law requires that the death carificate be executed

Completed by

Be

Medical Certification: To

Division of Vital Records, P.O. Box 68760,

Physician/Medical Examiner within 24 hours aftar death.

To the Funeral Diractor: Aftar this cartificata has been signed by the attanding physician and complately filled in by the funaral director, paga 2 should be datached for usa as tha burial-transit Sequentially list any, leading cause. Enter la Cause (Diseas that Initiated evresulting In dear

Director

Funeral

by

Completed

Be

**Physician** 

/Medical

Examiner

Funeral

**Director** 

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haaith and Mental Hygiena. Important: If Item 27 Is merked other than "natural", or Hems 23s or 28s-1 show any injury or other traumstic avent, Its Medical Examine must be notified at once.

Baltimore, Maryland 21215-0020

completion of cause of death?

1□ Yes 2□No 26. Place of Death (Check only one)

1□ Yes 212 No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

Hospital: 28a. Date of Injury (Month, Day Year) 5 Pending investigation

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

12 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Natural

2 Accident

4 Homicide

3 ☐ Suicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and talk of certifier

RESIDENT, MD.

29c. License number P-12560

1 Yes 2 No

29d. Date signed (Month, Day, Year) JULY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

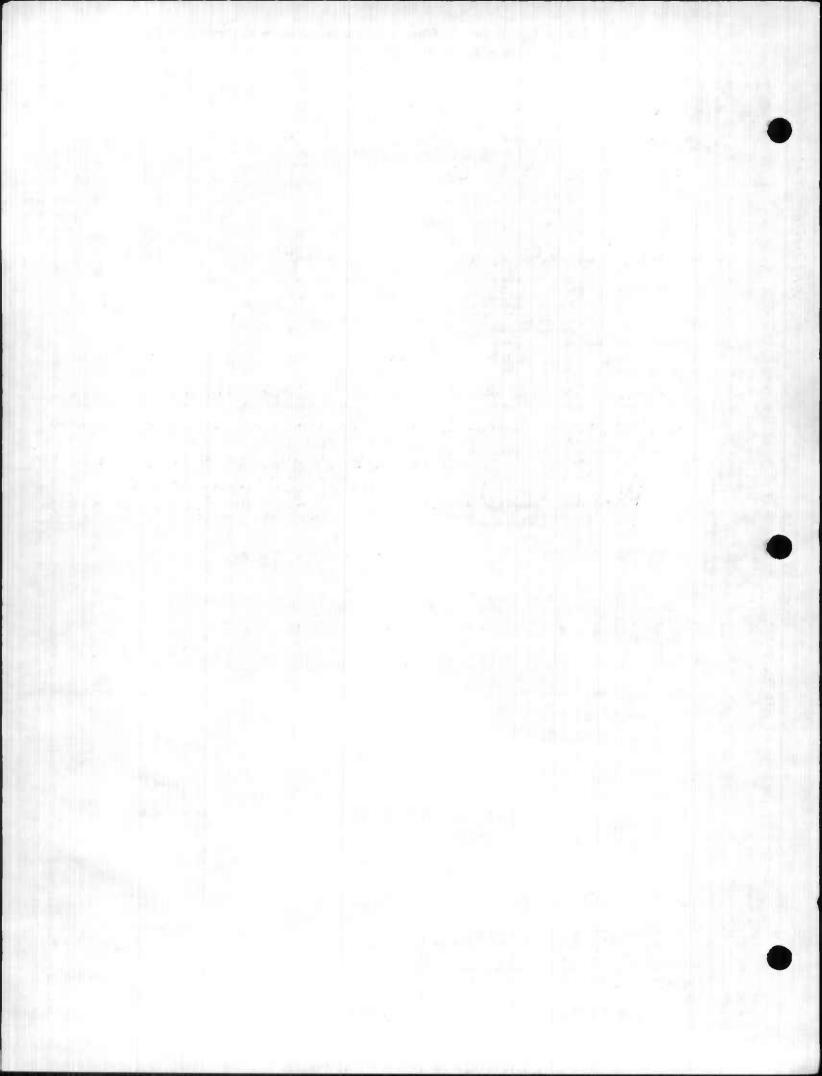
ANV GAGA, RESIDENT, DEPT. OF

OF MEDICINE, GOOD SAMARITAN HOSPITAL

State Registrar 31. Date filed (Month, Day, Year) AUG 0 3 1999

6 Could not be determined





State of Maryland / Department of Health and Mental Hygien

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No.	-	)	-	Li	-	0	U	
1e	0	0	2	1.	0	6	0	

3:30 A

Birthplace (State or Foreign Country)

Patterson, N.

10d. Inside City Limits 1 ☐ Yes 2 No

ASP		State of W	iaiyiailu		tificate of		iviental m	Reg. No.	99	242
Physician /Medica	Conctantin						2. Date of D Month	Day		3. Time
Examine		on, give street and number	)			4b. City, Town, BALTIM	or Location of Dea	ath 4c.	County of Des	
Funeral Director	5. Social Security Number  152-16-3742  Usual Residence of Decedent	6. Sex 1 ☑ M 2 ☐ F	ge (In yrs. las 74	st birthday) Yrs.	If Under 1 Year Months Days		in. (Month, D		9. Bio	thplace (State ountry) atter
Menyland and ahow Med at	10a. Stete 10b. Coun	y altimore		Town or Lor undal						10d. Inside
th with the Mer 23e or 28e-f al	10e. Street and Number 6740 Bren	twood Ave.			10f. Zip Code 212	22		10g. Citi	zen of What C	ountry?
filed within 72 hours after deeth with the Maryland Hygiene. "natural", or flema 23e or 28e-f show ant, the Medical Examinar must be notified at a Commission by Europea Dispersion	3 □ Widowed 4 □ Divorce	If Voc Give	? No WWTT		Vas Decedent of Yes, specify Cul		(Specify Yes or Nerto Rican, etc.)	lo-	14. Race - Am Black, Whi Specify: W]	
ed within 72 ho ygiene. eer then "netun rt, tre Medical	15. Decede (Specify only high Elementary/Secondary (0-12	ent'a Education est grade completed) College (1-4or	5+)	16a. Deced (Give I tife. D	ent's Usuat Occu kind of work done OO NOT use retin	pation during most of a ed)	vorking		nd of Business	/Industry
Saby a	17. Father's Neme (First, Middle			Rest	aurant	18. Mother's N	lame (First, Middl astasia	le, Maiden		s
1 and 2 and 2 and 2 and 27 le	19a. Informant's Name/Relation Stephanie 20e. Method of Disposition	Tahinos/W	ife 20b. Plac	674(		A boow	Rural Route Num			
permit. Pages 1 ar Department of Hea Important: if ham any Injury or othe pages.	1 Deurial 2 Cremation 4 Donation 5 Other 21. Signeture of Funeral Service	, ,,		«Lawn	Cemet	ery (	3-2-99		to.,Mo	
Physician /Medical	23a. Part1. Enter tha disease, shock, or heart feilure. Li			Do not ente	34 Wil	low Spi		. , Ba		

ss of Facility Ashton-Matthews Funeral Home, Inc low Spring Rd., Balto., Md. 21222

resulting In deeth)

scular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in death) Last

Physician/Medical Examiner

þ

Completed

Be

Medical Certification: To

3 Suicide

29a. Certifier

4 ☐ Homicide

bunial-transit

attending physician for use as the buna

been signed by the a should be detached t

page 2

certificate

this

After

completely filled in by the

Due to (or as a consequence of):

Due to (or as e consequence of)

Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco usa contribute to the cause of death? 4 Unknown

JULY 29, 1999

3 Probably

1 Yes 2 No 24a. Was an autopsy performed?

24b. Were autopsy findings available prior to

Approximate Interval Between Onset and Death

INSPECTION 1 ☐ Yes 2 No completion of cause of death?

(Check only one)

1 ☐ Yes 2 ☐ No

25. Was case referred to medical axaminer?				26. Place of [	Death
1 X Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient	3 DOA	Other: 4 Nursing	g Hon
27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	26b. Time of tnjury		tnjury at Work? 1 Yes 2 No	2

ne 5 Residence 6 Other (Specify) 8d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

6 Could not be determined 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

281. Location (Street and Number or Rural Route Number, City or Town, Stele)

29b. Signatu

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

eath (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year) AUG 03

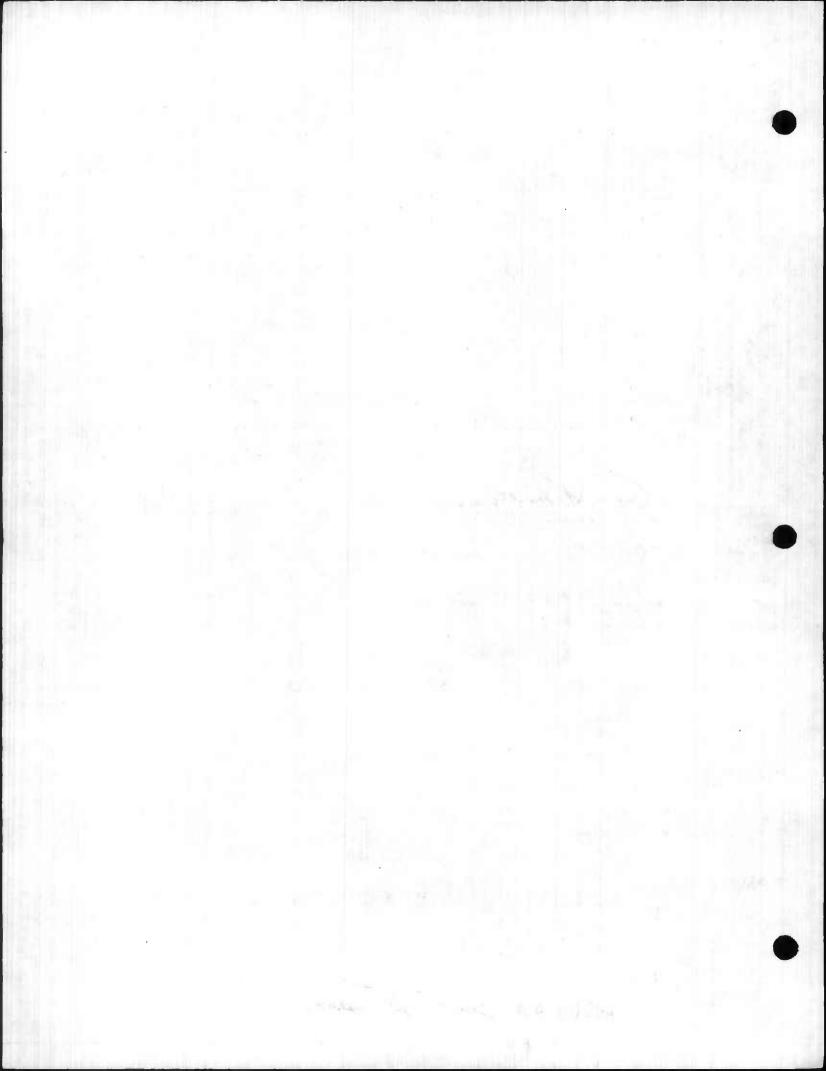
O.C.M.E

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760.

Hospital or Attanding Physician: The lew requires that the death certificate be executed 24 hours after death.

Funeral Director: A within 2 To the



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** VALENCIA JULY 1999 10:00 PM /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BERLIN NURSING & REHABILITATION BERLIN WORCESTER If Under 1 Year Months Days 5. Sociel Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (Steta or Foraign Country) Hours 214-16-6362 86 MARYLAND DEC. 17, 1912 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MARYLAND WORCESTER OCEAN CITY 1 ☐ Yes 2♥ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 PHILADELPHIA AVENUE 21842 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Merital Stetus Bleck, White, etc. 1 K) Yes 2 □ Nd 943 -1 Never Merried 2X Merried 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Year or Detes: 1946 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) AGENT INSURANCE 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be ANDREW VALENCIA THERESA BATTAGLIA 19e. Informent's Neme/Ralationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) MRS. MARY VALENCIA 9 PHILADELPHIA AVENUE, OCEAN, MD. 21842 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 A Burial 2 Cremetion 3 Removel from State
4 Dorretion 5 Other (Specify) MARYLAND VETERANS CEMETERY CROWNSVILLE, MD. 21. Signature of Furferal Ser 22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., ne 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 23a. Pert1. Saler the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each lina. Onset and Deeth Immediate Cause (Final disease or condition resulting in deeth) Antenn Disepan Conunany Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Nterios clesosi Physician/Medical Due to (or as a consequence of) Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the causa of death? 1 Yas 2 No 3 Probably 4 Unknown þ 24b. Wera autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy 1 Yes 2 No 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Deeth (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 Yas 2 No 2 Accident 6 Could not be detarmined 3 Suicide 28a. Plece of Injury - At home, ferm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stata) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and mannar as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a. Certifier 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) D02026

State Registrar

31. Dete filed (Month, Day, Year)
AUG 0 3 1999

FEDERICO G. ARTHES, M.D. 46 TEAL CIRCLE BERLIN MD 21811 32. Registrar's Signeture

30. Name and addrass of person who completed cause of death (flow 3a) (Type, Print)

**DHMH 16 Rav 6/95** 

**Funeral** 

Director

show

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filed within 72 hours after

Pages 1 and 2 should be nent of Health and Mantal

Department of Health and Important: If Item 27 is m any injury or other traum

**Physician** /Medical

Examiner

the burial-transit

for use as

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director, page 2 should

certificate

this funeral

After

within 24 hours after death. To the Funeral Director: A

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completely

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The law requires that the death certificate be executed

P.O. Box 68760

of Vital

Division

or Attending Physician:

Hospital

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21215-0020

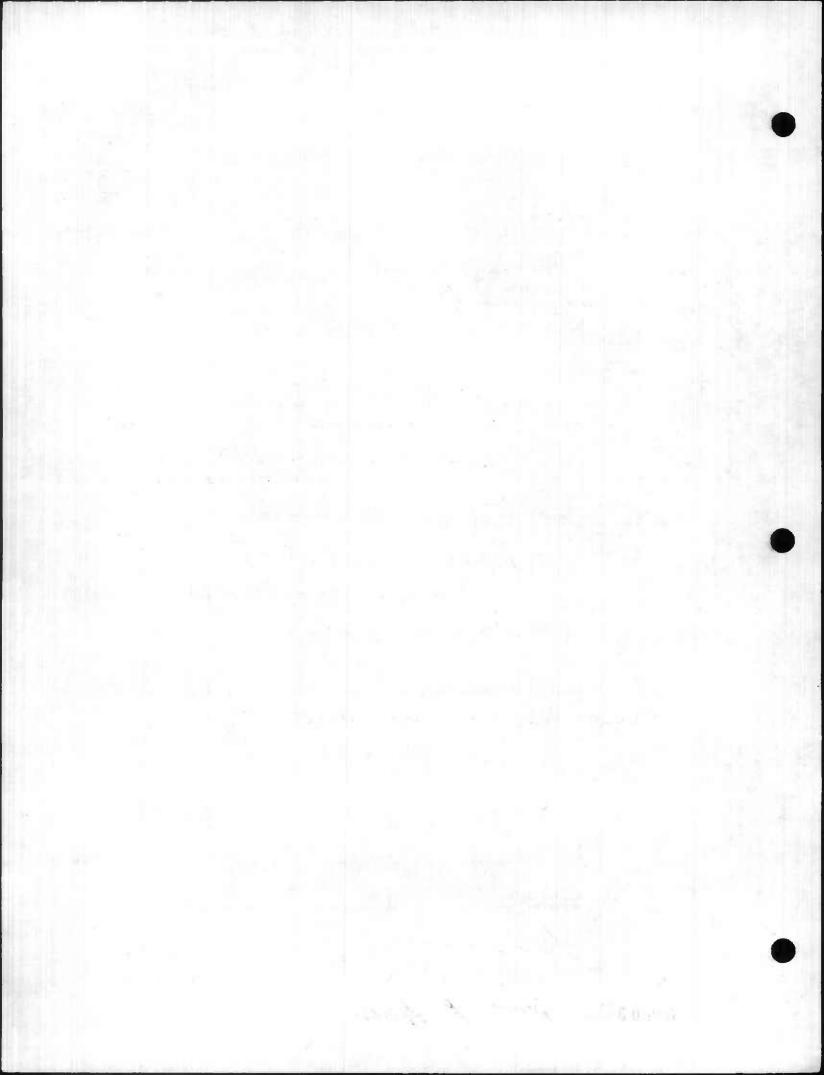
Maryland

altimore,

VALENCIA

HARRY

410-641-4400



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Watten 07 4a. Facility Nama (If not institution, giva streat and numbar) 4b. City, Town, or Location of Deeth 4c. County of Death coty Bult. CIt Bult. Good carl ta Hospital 5. Social Sacurity Number If Under 1 Yaar If Under 24 Hrs. Birthpleca (Stata or Foreign Country) 6. Sax 7. Age (In yrs, last birthday) Deys 263-38-2871 Hours 1XM 2 F Yrs. Usuel Rasidance of Dacedant 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 □ No Himore 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? Belvedere 4.5 1935 Avenue 21239 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No if Yas, Give Yeer or Datas: 13. Wes Decedant of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuben, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 1 Never Married 2 Married 1 Yas 2 No 3 ☐ Widowad 4 ☐ Divorced Specify: Black 15. Decedant's Education (Specify only highast grada completed) 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Collaga (1-4or 5+) Elamentary/Secondary (0-12) 12th grade 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Malden Surnama) Starks Warren 19a. Informant's Name/Ralationship (Type, Pnint) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Mary Vesta Belvedere Da 140, Md 21239 20a. Mathod of Disposition 1. Burial 2 Cramation 3 Ramoval from Stata 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) Dete 20c. Location - City or Town, Stata 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funerel Sarvica Licansee west 23a. Part 1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart tailure. List only one cause on each line. grenue red Approximata Interval Batween Onsat and Death Immadiata Causa (Final ardiae disaasa or condition rasulting in daath) Dua to (or as a consequence of) ASCVI Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or Injury that Initiated evants rasulting in daath) Lest Due to (or as a consequence of) Dua to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Donknown 1 ☐ Yes 2 ☐ No 24b. Wara autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yas 20 No

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

Director

Funeral

by

Completed

**Funeral** 

Director

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items 23a death

Pages 1 and 2 should be filed within 72 hours effer or nent of Health and Mental Hygiene. nt: If Item 27 ie marked other than "naturei", or iter

or other tree

Department of important: If any injury or once.

treumatic event, tre Medical

Baltimore, Maryland 21215-0020

the Maryland

iclan and burief-transit The law requires that the death certificate be executed P.O. Box 68760, the 80 980 bengis be ed b Records. cate hes been sig , page 2 should b Division of Vital

director, funeral

Physician/Medical Completed by Be

Examiner

certificate hes or Attending Physician: After this death. after death in by To the Hospital or within 24 hours aft To the Funeral Di completely filled in Medical

State Registrar

Certification: To

25. Was casa raferrad to medical axaminar? 27. Manner of Death

29b. Signature end title of certifie

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

28a. Data of Injury (Month, Day Year)

29c. Licansa number

28c. Injury at Work?

1 ☐ Yas 2 ☐ No

D28266

29d. Dete signed (Month, Day, Year) 8.3.99

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

26. Placa of Death (Check only ona)

Othar: 4 Nursing Homa 5 Rasidenca 6 Othar (Specify)

28d. Dascribe how injury occurred

30. Nama and addrass of persopt who complated cause of death (Itam 23a) (Type, Print) AyE WIN. MJ YORK Rd, BALTO, MD 21212 5010

31. Data filed (Month, Day, Year)

2 No

5 Panding

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6 Could not be datarminad

1 🗌 Yas

1 Natural

2 Accidant

3 Sulcida

29a. Cartifian

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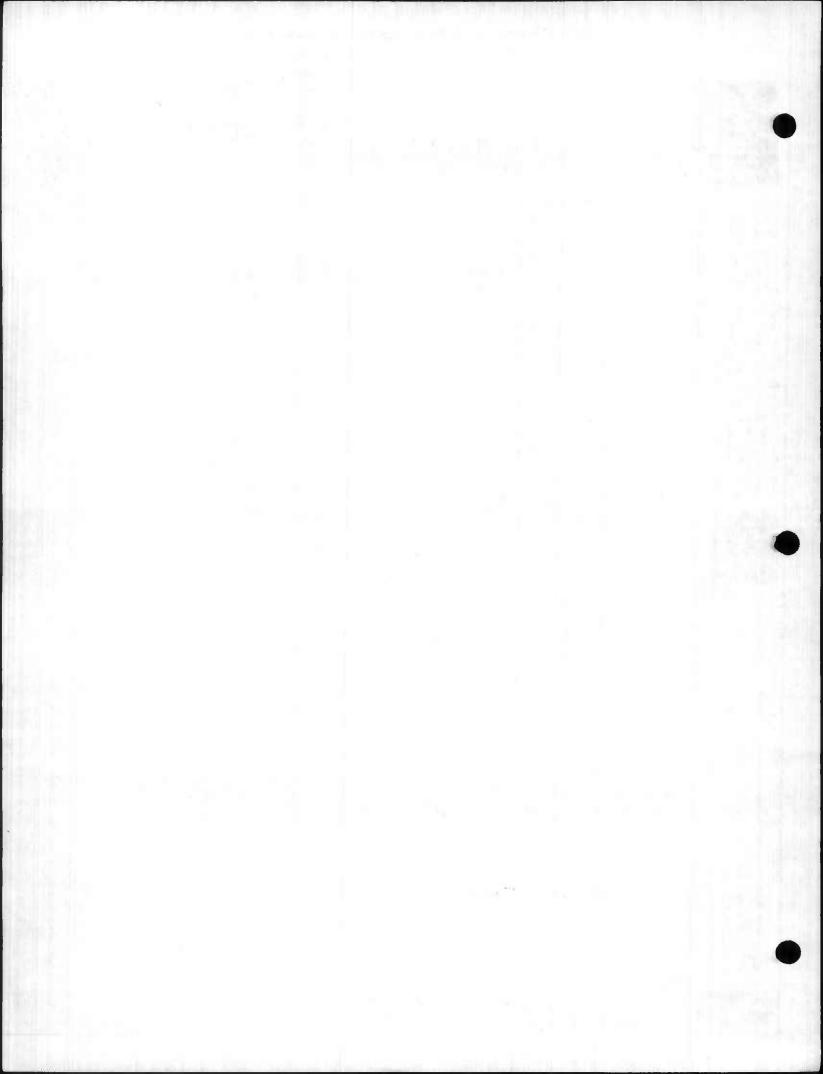
32 Ragistrar's Signatura

1 inpatient 2 DER/Outpatient 3 DOA

28a. Place of Injury - At homa, ferm, straet, fectory, office building, atc. (Spacify)

28b. Tima of

**DHMH 16 Rev 6/95** 



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ASP Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month **Physician** Jason L. White JULY 25 1999 2356 /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3100 SWANN DRIVE BALTIMORE If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 15 M 2□ F 19 Yrs. 217-94-0506 **Director** 03-07-80 MD Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show MD NA Baltimore Director Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 238 1347 Walker Avenue 21239 USA Funeral **Barrier** 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - Amarican Indian, Bleck, Whita, etc. filed within 72 hours after Yas 2 No 1X Never Merried 2 ☐ Merried b Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: Black þ 3 Widowed 4 Divorced Yeer or Detas: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Businass/Industry mentery/Secondery (0-12) College (1-4or 5+) 10th Grade NA Paint Mixer Sherwin Williams 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Pages 1 and 2 should be nent of Health and Mental 7 is merked of traumatic evi-Robert J. White Rochelle Shelton Spriggs 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Rochelle Shelton Spriggs 1347 Walker Avenue Baltimore, MD. 21239 20b. Plece of Disposition (Nama of 20a. Method of Disposition Dete 20c. Location - City or Town, Steta cemetery, cremetory or other piece) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Cemetery 08-04-99 Baltimore, MD 21. Signeture of Fyneral Service Licensee 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue Part1. Entar tha diseasa, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiretory arrest shock, or heart fellure. List only one cause on each line. Approximete Interval Between Onset and Deeth Physician /Medical Immediete Cause (Final disease or condition resulting in death) tot que Examiner Examiner The law requires that the death certificate be executed bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last pug Due to (or es e consequence of): Physician/Medical the Due to (or es a consequença of) signed by the a Pert II. Other algnificant conditions contributing to deeth but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 certificate or Attending Physician: funeral director, Be 25. Was case referred to medicat 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) SCENE Medical Certification: To TX Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 26b. Time of Injury 28d. Describe how injury occurred 27. Menner of Death 28a. Dete of tnjury (Month, Day Year) 28c. tnjury at Work? Affer 1 Netural 5 Pending Found 7/25/88 1 Yes 24 hours after death. Investigation 2340 2 Accident 6 Could not be determined 3 Suicide 4 Homicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) Location (Street and Number or Rural Route Number City or Town, State) 3 100 CCC SW in by Wany Drive Bettimore pick bach 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, and due to the cause(s) and manner as stated. Hospital 29e. Certifier (Check only one) Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and dua to the cause(s) and menner stated. within 2 To the \$ 29b. Signatura and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E JULY 26,1999 no 30. Name and address of person who completed cause of eeth (Item 23a) (Type, Print)

Box 68760.

P.O.

Division of Vital Records.

**DHMH 16 Rev 6/95** 

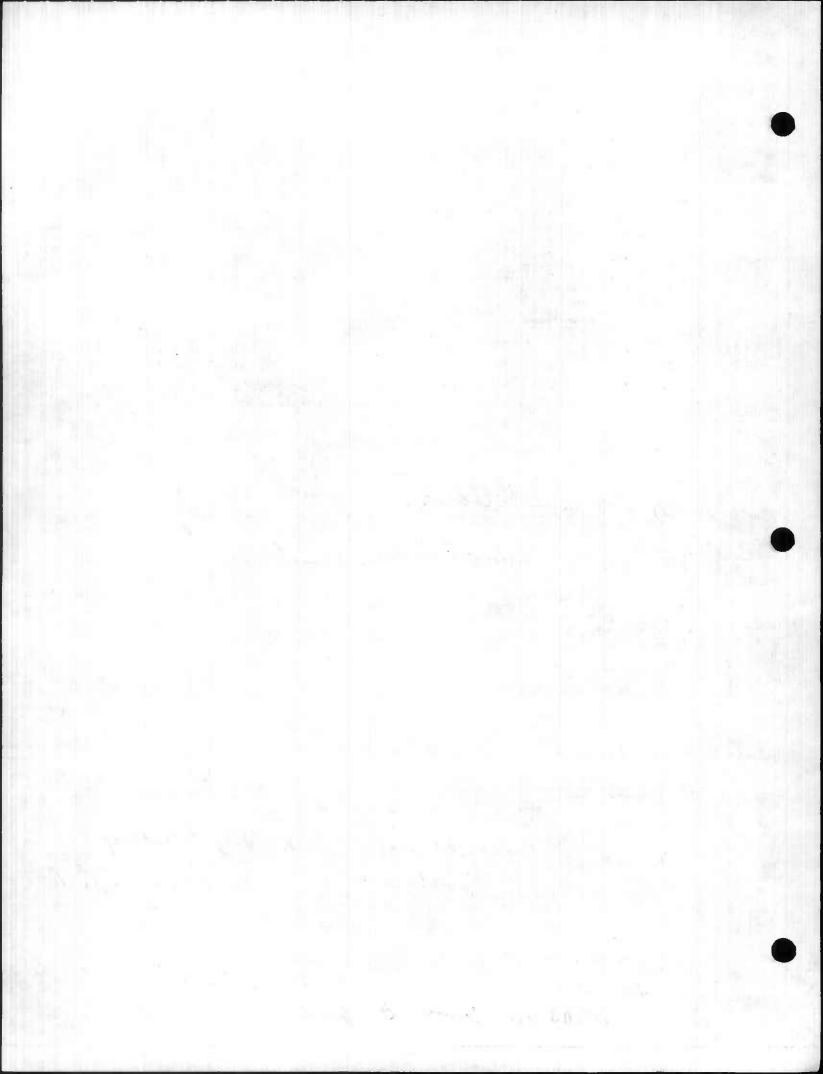
State

Registrar

(Month, Day, Year) 32. Registrar's Signeture 1999 AUG 03

-DOOREM, KING

111 Penn Street, Baltimore, Maryland 21201



#### Please Type or Print in Biack Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Dete of Death cedent's Neme (First, Middle, Last) Month **Physician** 1005 JULY /Medical not institution, give street end number) 4b. City, Town, or Location of Deeth Examiner jenera Sociel Security Number **Funeral** 248-60-4530 Usuel Residence of Decedent 1 □ M 2 X F Months Deys Hours Director with the Maryland 10b. County 10a State 10c. City, Town or Locati 10d. Inside City Limits 7 is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Maryland 1 X Yes 2 □ No Director IMOTE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece -American Indien. 11. Maritel Stetus Bleck, White, etc. permit. Pages 1 end 2 should be filed within 72 hours efter obsartment of Health and Mentel thygiene. If tem 27 is marked other than "natural", or ite. 1 Never Married 2 Merried Maryland 21215-0020 1 ☐ Yes 2 No Specify: by -Americ 3 Widowed 4 □ Divorced Completed 16e. Decedant's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Elemantary/Secondery (0-12) Collage (1-4or 5+) 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Meiden Surname) Vaterman Trailes Ola 19a. Informent's Name/Reletionship (Type, Print) (daughter) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Md. Z emar ppa 6 0 Baltimore, 20b. Plece of Disposition (Neme of cemetery, cremetory or other 20e. Method of Disposition /Detg 20c. Loc 1 Burial 2 Cremetion 3 Removel from State injury or fingham Bapt. Ch. Cem. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility 21. Signature of Funeral Service Licen Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiratory errest, or heart failure. List only one cause on each line. tom unera 21216 Approximete Intarval Between Onset and Deeth **Physician** CEREBIAL VASCULAR ACCIPENT /Medical Immediate Cause (Final yeary disease or condition resulting in deeth) Examiner Due to (or es e consequence of) Examiner Sequantially list conditions, if eny, leeding to immediate causa. Enter Underlying Ceuse (Diseese or injury that initiated avants resulting in death) Last Due to (or as a consaquence of): and physician Physician/Medicai the Due to (or es e consequence of) **esn** Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contributs to the causs of death? 1 Tyss 2 No 3 Probably 4 Unknown signed by Hepat Fr. lust þ should be 24b. Were autopsy findings evelleble prior to completion of cause of deeth? Sepsis poss aro sensis Completed 24e. Wes en eutopsy 1 ☐ Yes > No this certificate 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: funeral director, 25. Wes casa refarred to medical examiner? Be 26. Pleca of Daeth (Chack only one) Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 □ ER/Outpetient 3 □ DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Dascribe how injury occurred After Nature 5 Pending 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 Yes 2 🗆 No death. 2 ☐ Accident investigation ofter death Director: 6 Could not be datarminad 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 - Homicide To the Hospital of within 24 hours et To the Funeral D Certifying Physician: To the best of my knowledge, deeth occurred at the tima, data end place, and due to the causa(s) and mannar as stated. 2 Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, daath occurred at tha time, dete and place, end due to the causa(s) and mennar statad. 29a. Certifier Medical 29d. Dete signed (Month, Dey, Year) 29c. License number 29b. Signeture end title of certifier 30 July - MA

State Registrar 31. Dete filed (Month, Dey, Year) AUG 0 3 1999

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30. Name end address of person who completed ceuse of deeth (Item 23a) (Type, Print)

ALEARD SPANUS ( 15 W. )

22. Ragistrer's Signetura

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W. MACPHALL BELAIR MD



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24265 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Date of Death Dev Month Year **Physician** Mildred Μ. Wills 1999 August 10:00 a.m. 2, /Medical 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner N/A 4212 Woodlea Avenue Baltimore If Under 1 Year If Under 24 Hrs. Birthpleca (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 10 M 20 F 58 218-36-2299 Director 18, Maryland Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahoa 1 Yes 2 No Directo Maryland N/A Baltimore 288-1 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò United States 4212 Woodlea Avenue 21206 or Barns 23a Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 14. Race - American Indian, Bleck, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White ģ 3 Widowed 4 Divorced natural Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Claims Representative Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Montal Hi Important: If New 27 is marked oth any Injury or other traumatic even 2058. Be Pages 1 and 2 should be Harvey J. Wills Dora Κ. Morgal 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Nancy E. Smith (Cousin) Baltimore, MD 2618 Hillcrest Avenue 20e. Method of Disposition
1 ☑ Burial 2 ☑ Cremetion 3 ☑ Removel from Stete 20b. Pleca of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, State 8/5/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 21. Signeture of Funerel Service Licensee Michael E. Canapp 22. Neme and Address of Facility 5305 Harford Road LEONARD J. RUCK, INC. Baltimore. 21214 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one ceuse on each line. Approximete Interval Between Onset end Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Examiner SCVI physician and s the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Box 68760 Physician/Medical 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Records, P.O. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were sutopsy tindings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? 1 ☐ Yes 2 1 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? Be 28. Placa of Deeth (Check only one) Hospitel: 1 ☐ Inpatient Other: 4 Nursing Home 5 Praesidence 6 Other (Specify) 1□ Yes 2 No edical Certification: To 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Day Year) 27. Manner of Death 1 PiNeturel 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of After 5 Pending 1 Yes 2 No death investigation 2 Accident 6 Could not be determined 3 Sulcide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

Division of Vital or Attending Physician: n 24 hours after death.

• Funeral Director: A pletely filled in by the fi Hospital To the Hosp within 24 hos To the Fune completely fi

State

29e. Certifier

(Check only one)

29b. Signeture and fittle of certified

Registrar

**DHMH 16 Rsv 6/95** 

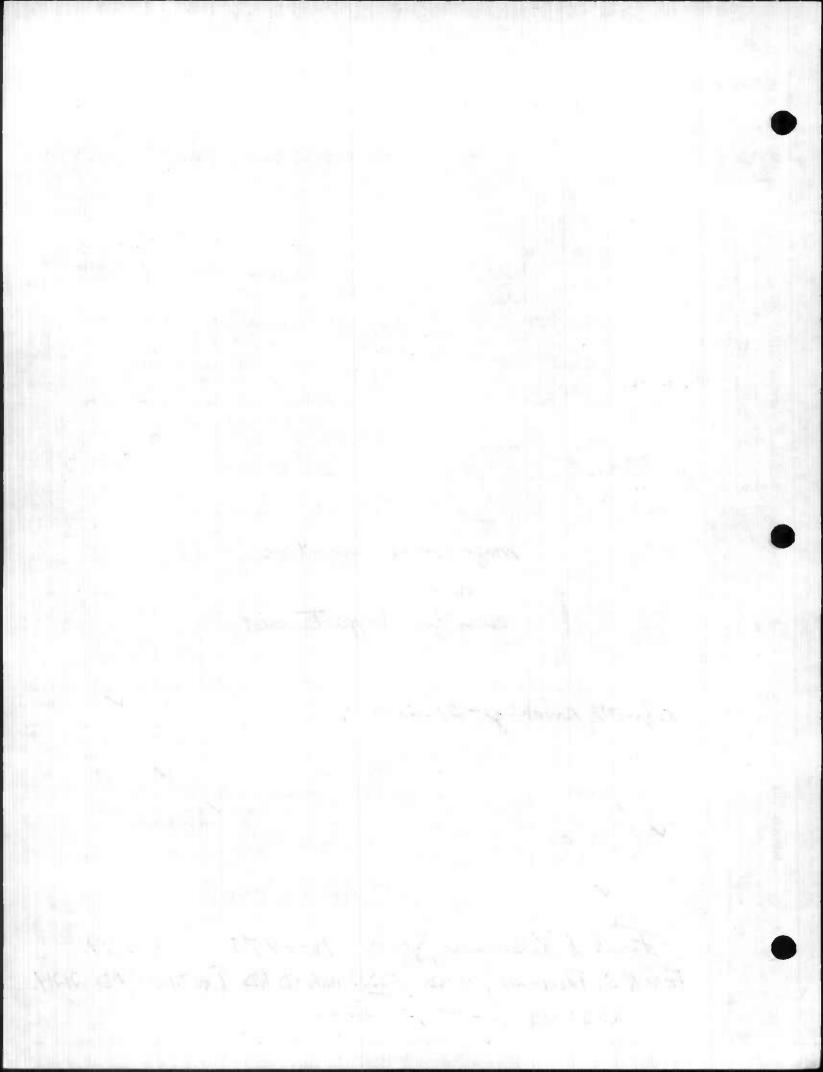
31. Dete filed (Month, Day,

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner steted.

29d. Dete signed (Month, Day, Year)



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Dey 9 19 9 Month WOOD **Physician** 2 DULV /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FLLICOT OAD CITY MMEDE HOWARD 6 8. Date of Birth Month, Day, JUNE 3, 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sax 9. Birthplaca (Stete or Foreign Country) **Funeral** 240-60-961 1 M 2 F Days Months Hours 42 NORTH CAROLINA Yrs. Director Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Yas 2□No MARYLAND Director 288-13 HOWARD LICOTT 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 8 326 8 3 / 0 43

13. Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarro Ricen, etc.) USA

14. Race - American Indisn, KOAD Funeral 12. Wss Decedent Evar in U,S. Armed Forcas? 1 ☐ Yes 2 N No If Yes, Give Yeer or Dates: 11. Mentel Stetus Bleck, White, etc. 72 hours after 1 Nevar Marriad 2 Merried 1□ Yes 20 No 21215-0020 8 Specify: þ BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. filed within Elementary/Secondary (0-12) College (1-4or 5+) DAY CARE NURSERY TOR BACHELOR DEGREE Baltimore, Maryland 17. Father's Nema (First, Middla, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Pages 1 and 2 should be fill mant of Health and Mental Hitant: If flem 27 is marked off Be S 19e. informent's Neme/Reletionship (Type, Pnint) 19b. Melling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) ELLICOTT (171, 140. 21643 KODDIE HUSBAND 3268 EL WOOD 20b. Ptece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Buriel 2 Cramation 3 Removal from Stete RIDGE CEMETERY 8-2-99 4 ☐ Donetion 5 ☐ Other (Specify) BALTIMORE, MARYLAND 21. Si@Neture of Funeral Service Lie 22. Name and Address of Facility FUNERAL HOME BROWN JR. 2140 N. FULTON AVE. 23e. Par 1. Enter the disease, or complications that caused the death. Do not entar the mode of dylng, such as cerdiac or respiretory as shock, or heart feilure. List only one cause on each line. Approximata Intervel Between Onsat and Death **Physician** schemia /Medical Immediete Ceuse (Final disaese or condition resulting in deeth) Examiner due to (or es a consequence of): Physician/Medical Examiner Me l'abetes The law requires that the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Last Due to (or es e consequence of) Box 68760, Dua to (or es a consequence of): 94 igned by the ette Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yea 2 No 3 Probably 4 Onknown Hypercholesterolemia of Vital Records, Completed by 24b. Were autopsy findings available prior to 24a. Wes en eutopsy performed? completion of cause of death? certificate has 2 DINO 1 ☐ Yes 2 ☐ No 1 ☐ Yes or Attending Physician: 25. Was case referred to medicel examiner? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Homa 5 Mesidence 6 Other (Specify) Medical Certification: To 1 Yes 2 100 1 Inpatiant 2 ER/Outpetient 3 □ DOA After this 28a. Dete of tnjury (Month, Day Year) funeral 27. Menner of Death 28b. Time of tnjury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Division 1 PNeturel To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Aftr 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rurel Routa Number, City or Town, Stete) Plece of tnjury - At home, ferm, street, fectory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier (Check only one) 29b. Signeture end title el/certifier 29c. License number Pata signed (Month, Dey, Year) 30 30. Name and address of person d cause of deeth (Item 23a) (Type, Print) BACT MD 21215 BELVEDERE 35 MD KERKULIET Gar

State Registrar

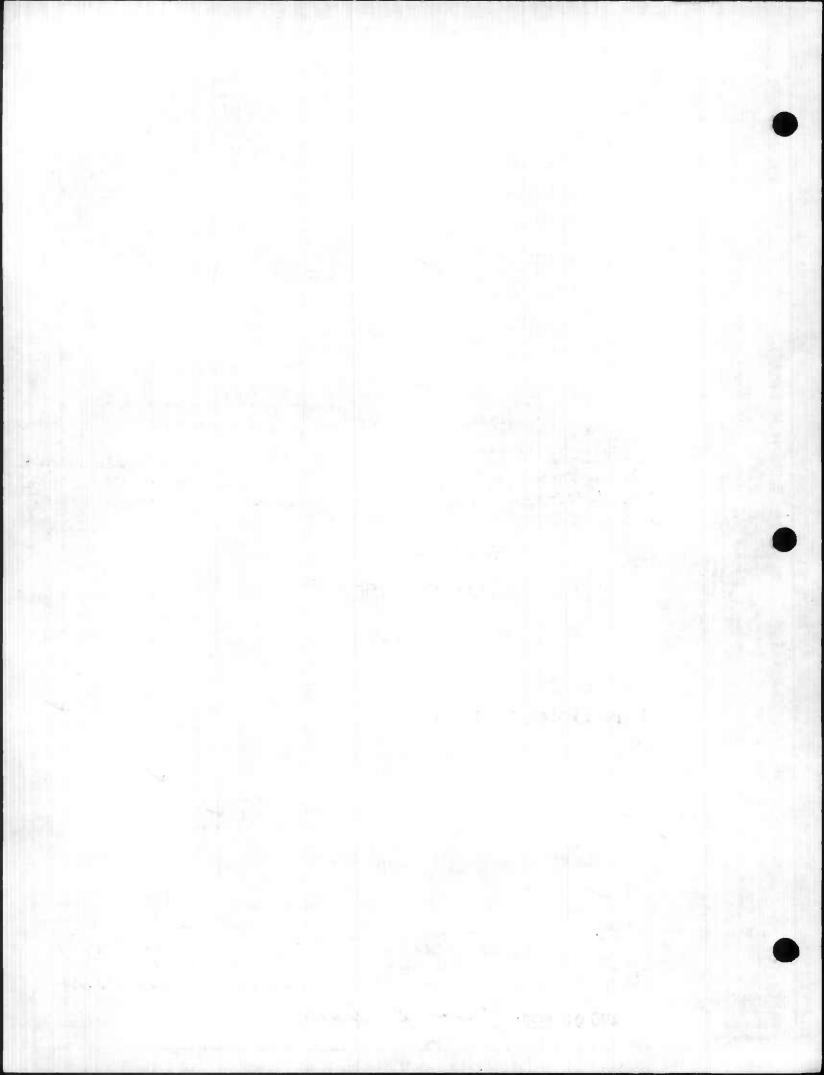
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31. Dete filed (Month, Day, Year)

32. Registrar's Signeture

B. Sporks



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Deeth Month 1043 AM mestine 30 1999 JULY 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL BALTIMORE If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Hours 1□ M 2 F 231-30-5322 Vrs Usual Residence of Decedent 10a. State 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 No Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 430 1 21215 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 20 No
H Yes, Give
Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Naver Married 2 Married 1 Yes 2 No Specify: Specify: 3/ach 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hospital - Nursing Elementary/Secondary (Q-12) College (1-4or 5+) Home 12th grade Murse NA 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ddie Wood 1aylor 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Randallstown, ad Niece Zurich Road 20b. Place of Disposition (Name of cemelery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Ramovai from Stata Cenetery 4 □ Donation 5 □ Othar (Specify) 8-4-99 21. Signature of Funaral Service Licansee 22. Name and Address of Facility 21215 23a. Part1. Entar the disaase, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feliure. List only one ceuse on each line. Belto, red Approximate Interval Between Onset and Death Immediate Ceuse (Finel disease or condition resulting in death) < 36 HOURS . HEMORRHAGIC CEREBROVASCULAR ACCUDENT Due to (or as a consequence of): >20 YEARS HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown TYPE II 2) CONGESTIVE 1) DIABETES MELLITUS HEART FAILURE 3) GRAVES DISEASE 4) ATRIAL FIBRICATION performed? 24b. Were autopsy findings available prior to completion of cause of death? 5) END STAGE RENAL DISEASE 6) COLONARY ARTERY DISEASE 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Placa of Death (Check only one) Hospital: 1 Inpetient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Netural 5 Pending investigation 2 Accident 1 Yes 2 No 6 Could not be determined 3 ☐ Suicida 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Placa of Injury - At homa, farm, street, factory, office building, etc. (Specify)

**Physician** /Medical Examiner P.0. Division of Vital Records,

Saltimore, Maryland 21215-0020

Pages 1 and 2 should be

Department of Health Important: If Item 27

Hygiene.

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Examiner

Physician/Medical

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(Check only one)

29b. Signature and title of certifian

PETA-GAY JACKSON

29a. Certifier

physician and the burial-transit

**Funeral** 

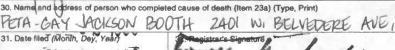
Director

been signed by the attending I should be detached for use as death. or Attend after death Director: / Hospital 24 hours 8 24 hours To the Hosp within 24 hor To the Fune completely fi

DHMH 16 Rev 6/95

State Registrar

31. Date filed (Month, Dey, Year) AUG 0 3 1999



MEDICAL RESIDENT

BALTIMORE, MD

1999

JULY

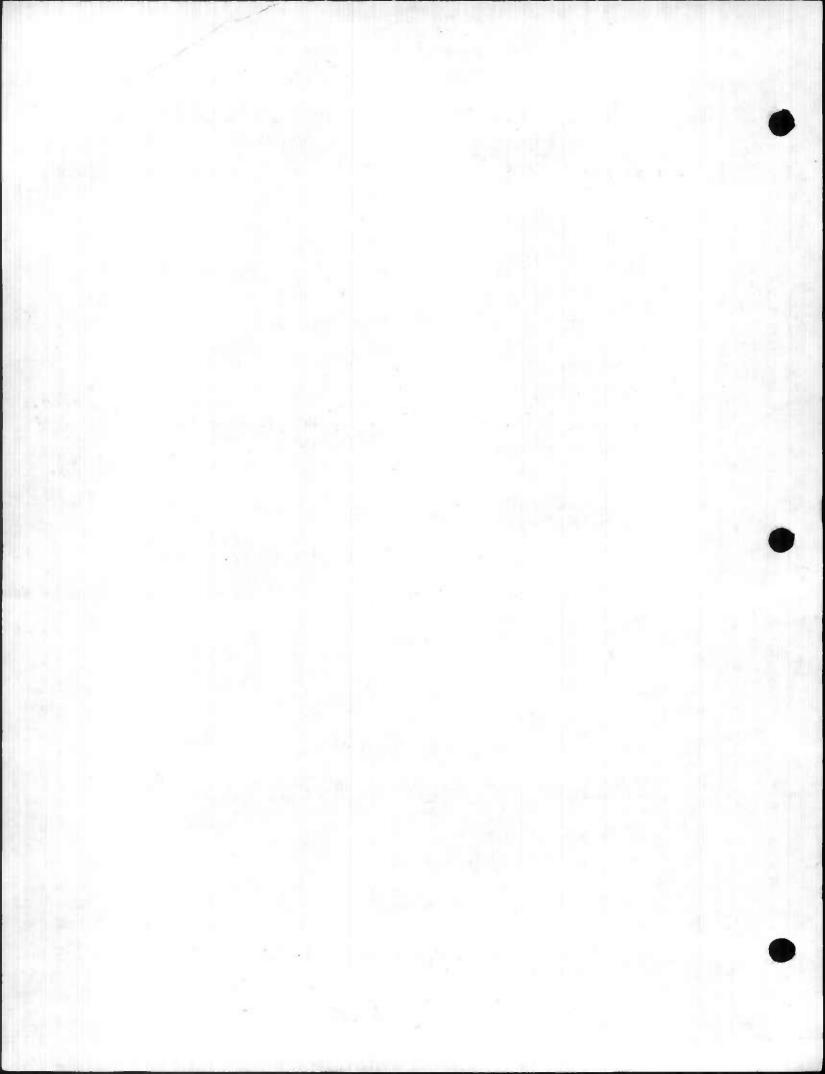
29d Date signed (Month, Dev. Year)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the ceuse(s) and manner stated.

29c. License number

D0052122



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q 24268 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician E WILSON CATHBEINE JULC 6 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner County Olumbia General tto ward If Under 24 Hrs. If Under 1 Yeer 8. Date of Birth (Month, Dey, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 ■ M 2 XF 212-36-0696 Yrs. 0 Director Ma Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits flam 27 is marked other than "natural", or flams 23a or 28a-f show other traumatic avent, the Medical Examiner must be notified as 1 Yes 2 No Director Olumbia Ma Ward 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Rivendel 5255 21044 U.S.A Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus permit. Pages 1 and 2 should be filled within 72 hours after to Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or than any injury or other traumatic avent, the Medical Essentiation. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yas, Give Yeer or Detes: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Black Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry School Elementary/Secondary (0-12) College (1-40r 5+) Zyears Hide eacher 17. Father's Name (First, Middle, Last) 18. Molher's Name (First, Middle, Maiden Sumame) Be oses Beatrice Owens 10 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurat Route Number, City or Town, State, Zip Code) 2/04/ 255 Walters - Husband Olumbia. ivende ( Wilson 20a. Method of Disposition
1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other placa) 20c. Location - City or Town, State Randallstown, red 4 Donetion 5 Other (Specify) Mem Lon 21. Signature of Funeral Service Licensee 22. Name and Address of Facility lasi Balto, mel ualash Avenue 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical MYDGEDIAL 6 HOURS POSSIBLE INFARCTION Examiner Due to (or as a consequenca of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of): Box 68760 Physician/Medical Due to (or es e consequença of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? à 1 ☐ Yee 2 ZNO 3 Probably 4 Unknown POST-OPBRATIVE MULTIPLE STATUS of Vital Records, py 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Completed RBSBCTLANS AND OF ABDOMINIAL WOMB 1-ELYes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) 12 Yes 2□ No Hospital: Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) Certification: To Attending Physi 1 Inpatient 2 ER/Outpatient 3 DOA 曹 27. Menner of Death 28d. Describe how injury occurred 28a. Date of tnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? Division After Netural 5 Pending death. 1 ☐ Yes 2 ☐ No investigetion 2 Accident after death Director: A d in by the f 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral E completely titled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or Investigation, in my opinion, death occurred at the time, dete and placa, and due to the cause(s) and manner stated. 29a. Certifier edical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) neve - berry D 17502 29. JULL 1991 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) RENE L GETBER 14201 LAUREL PARK OR

State Registrar

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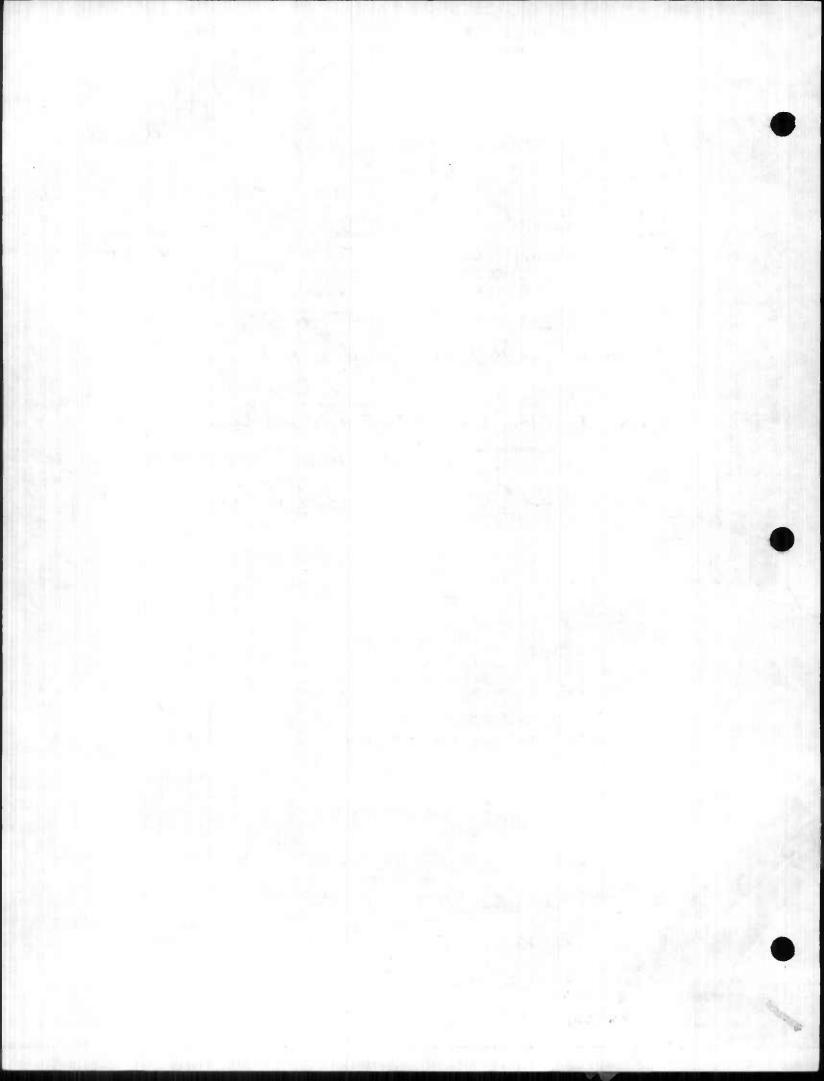
31. Date filed (Month, Day, Year)

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32. Registrar's Signature

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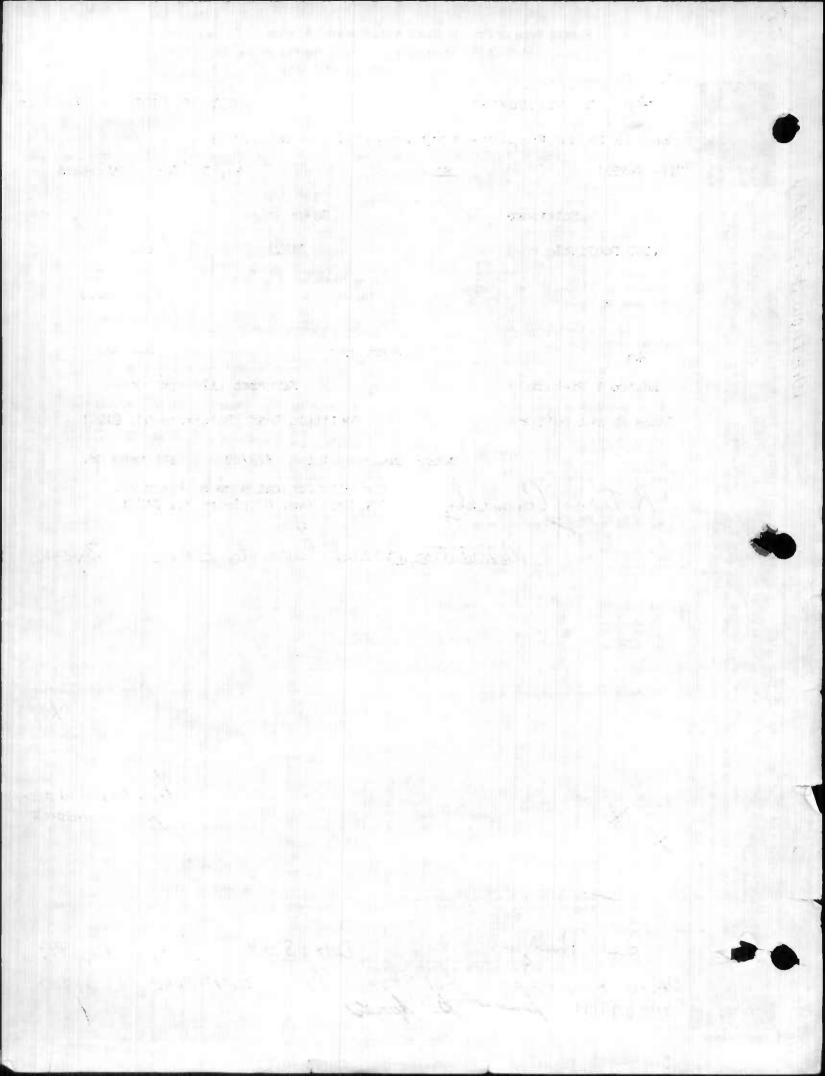


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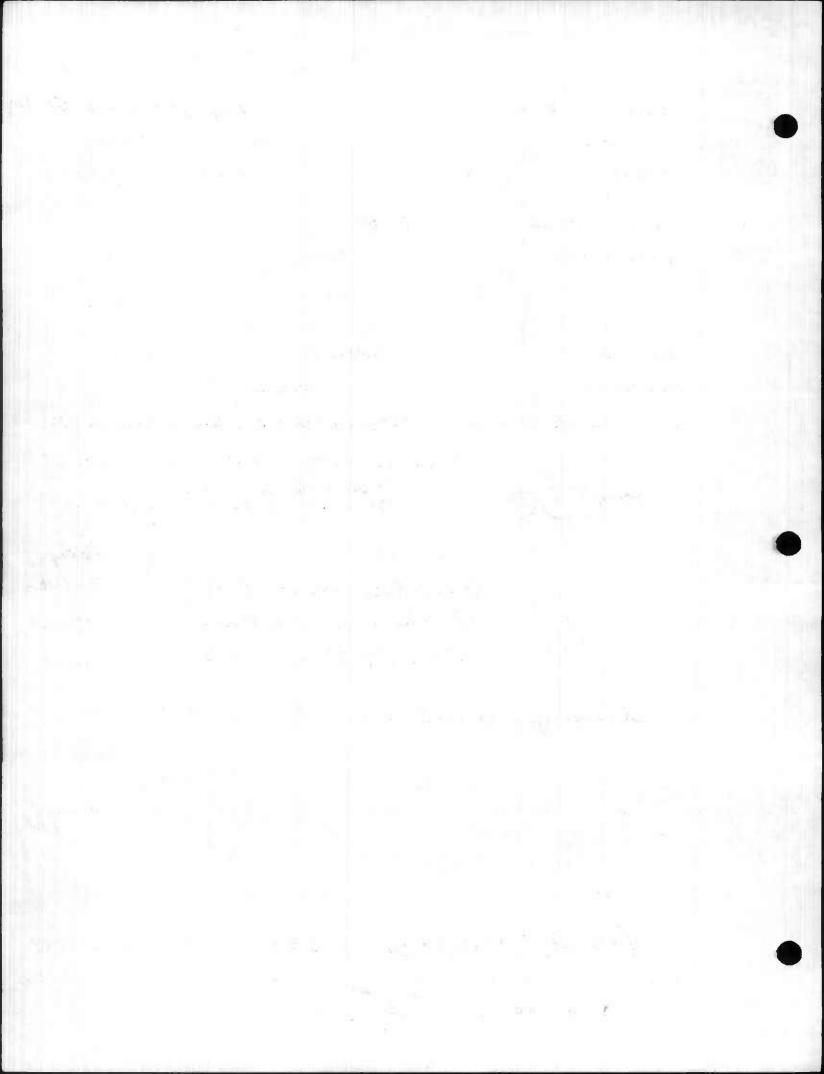
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death AMEND #7 PER F.H. G774 8-3-99 J.A 2. Date of Death 3. Time of Death 1. Decedent's Nema (First, Middle, Last) JULY 30 Day 999 Yaar Physician 7:15 am D WIATROWSKI /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice-Mercy Hospital Baltimore if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 30 1946 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foraign **Funeral** 1 M 2 X F Months Days Hours .63 53 Yrs. 218-44-9931 MAryland Director Usuai Residenca of Decedent 10e State 10h County 10c. City. Town or Location 10d. inside City Limits Items 23s or 28s-f short ner must be notified at Md Baltimore Essex 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1613 Doolittle Road 21221 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yas, Give Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status 7 is marked other than "natural", or iten traumatic event, the Medical Examiner Black, Whita, atc. 1 Never Married 2 Merried Specify: White 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elemantary/Secondary (0-12) College (1-4or 5+) Homemaker own home 9th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middla, Last) s 1 and 2 should be fit I Haalth and Mental H tem 27 is marked oth Edward I Wiatrowski Margaret Elizabeth Combs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a, informant's Name/Relationship (Type, Print) permit. Pagas 1 and 2
Department of Haalth as
Important: If item 27 is a James Eugene Bolt/son 1613 Doolittle Road Baltimore Md. 21221 Baltimore. 20b. Placa of Disposition (Name of cematary, crematory or other placa) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 8/2/99 Metro Crematory Inc Baltimore Md. 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility 21. Signature of Funeral Service License Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221 030 Approximate interval Batween Onset and Death 23a. Part1. Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each line. hysician Cancerto Bones /Medicai Immediate Cause (Fine) disaasa or condition resulting in death) Examiner Due to (or as a consequenca of) Examiner physician and s the bunel-trans Sequentielly list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medicai Due to (or as a consequance of): 88 usa Part fi. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the causs of death? 1 Yes 2 No 3 Probably 4 Unknown 3 pe þ Sign 24b. Wera autopsy findings available prior to Completed 24e. Was en autopsy peen performad? completion of cause of death? has 1 Yes 2 No 1 Yas 2 No cartificata or Attending Physician: MARIS IST MERCY Be 25. Was case refarred to medical examiner? 26. Placa of Death (Check only one) FE / A Other: 4 Nursing Homa 5 Residence 6 Other (Specify) HOSpice 1 Yes 2 No 2 1 Inpatiant 2 ER/Outpatient 3 DOA this funarai 27. Menger of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 28a. Date of Injury (Month, Day Year) Aftar 5 Pending Investigation 1 Naturel 2 Accident after death. 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of fnjury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homlcide e Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifiar (Check only one) within 2 29d. Date signed (Month, Day, Year) 29c. Licensa number 29b. Signature and title of cartifie 30. Name and address of person who completed cause of deeth (item 23a) (Type, Pri BALTIMORE, MD 301 St # 32. Registrar's Signatura Registrar

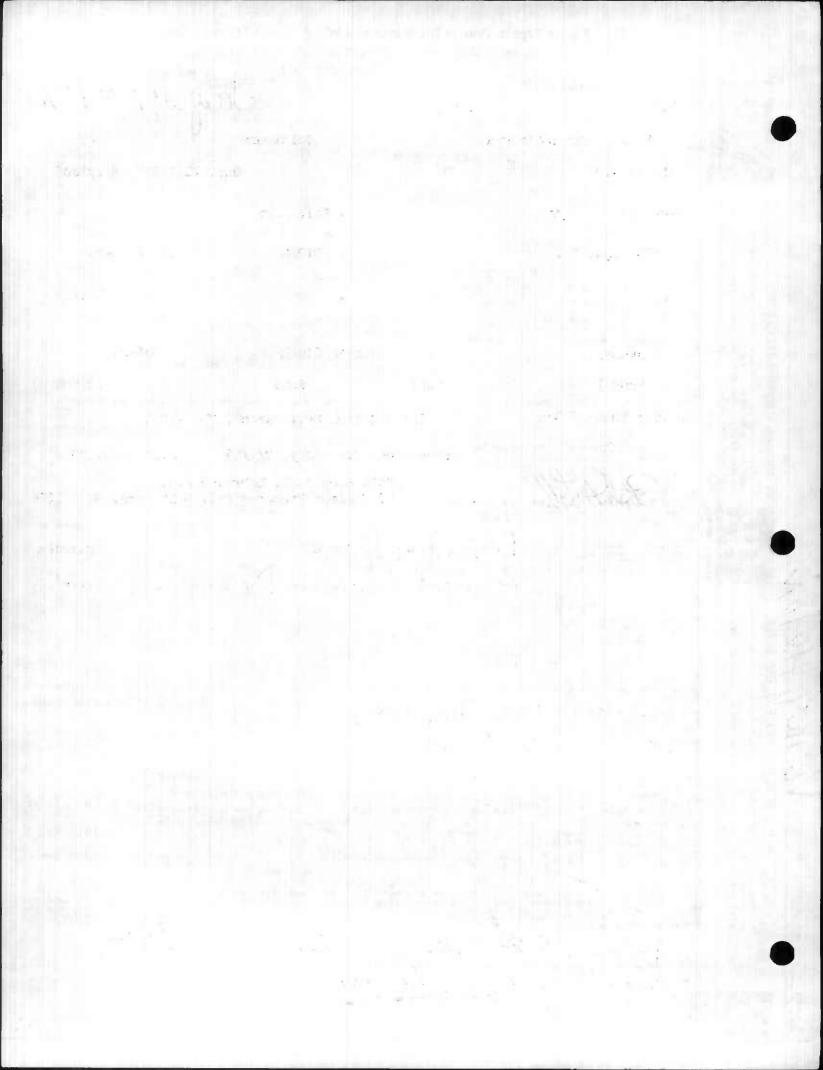


State of Maryland / Department of Health and Mental Hygiene

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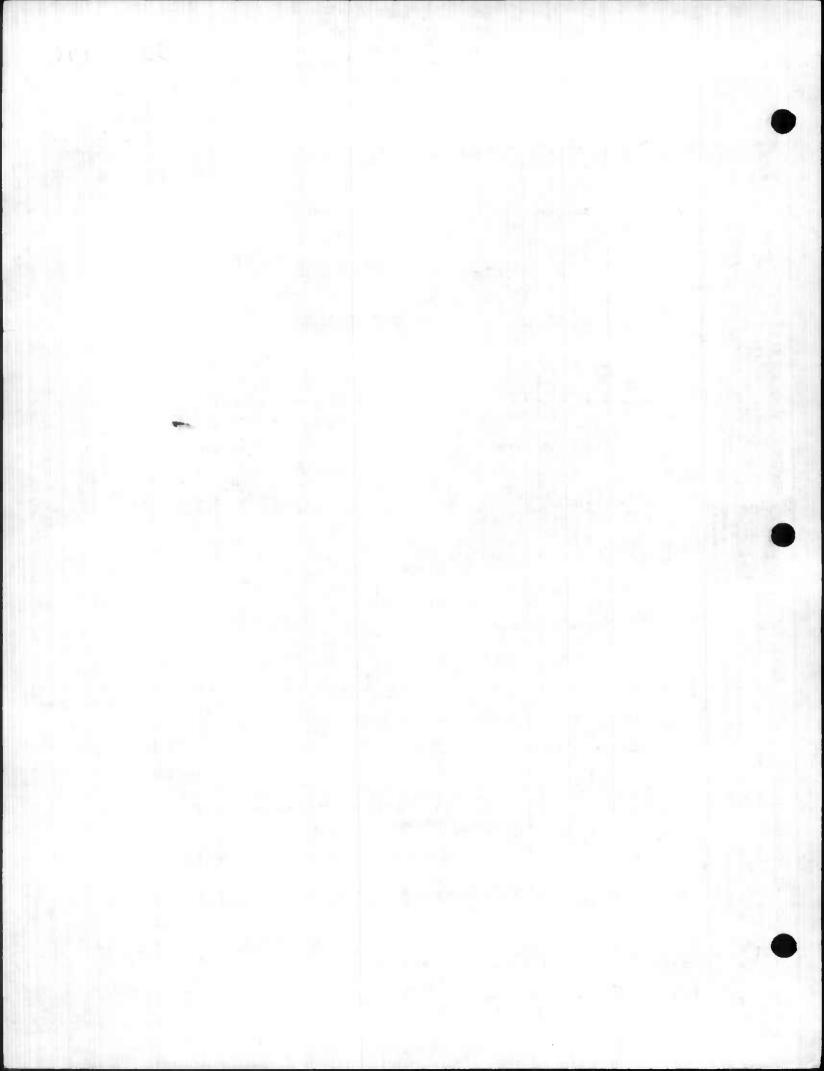
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of **Physician** Young /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Deeth Examiner Levindale Nursing Center Baltimore n/a 5. Social Sacurity Number Birthpleca (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** 1□M 2X F Months Days Hours Yrs. 77 213 14 8709 Oct. 22,1921 **Director** Maryland Usuel Residence of Decedent with the Maryland 10c. City, Town or Location 10e. Stete 10b. County 10d. Inside City Limits ns 23a or 28a-f show must be nothing at Maryland n/a Baltimore 1 X Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 600 Light St. 21230 United States death Funeral ral', or items 2 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yas, Give Year or Dates: 14. Race - Amarican Indian, Bleck, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-ff Yas, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Stetus filed within 72 hours after 1 Never Merried 2 Married Baitimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White by 3CXWidowed 4 □ Divorced "natural", Completed permit. Peges 1 and 2 should be filed within 72 ho Department of Heelih end Mental Hygiene. Important: If them 27 is marked other than "natur any Injury or other traumatic event, the Medical 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) (Unknown) Counter Clerk 17. Fether'a Nama (First, Middle, Last) 18. Mother's Nama (First, Middla, Maiden Surname) Be Ka1h (Unknown) Anna (Unknown) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Walter Young / Son 29537 Golton Dr., Easton, MD 20b. Pleca of Disposition (Nama of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 8/4/99 Green Mount Crematory Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD Doluman 21286 23a. Part1. Eliter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrast, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final diseese or condition resulting In death) /Medical months **Examiner** Examiner Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es a consequence of) Physician/Medical Due to (or as e consequenca of): 88 use Pert II. Other signiffcant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dfd tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24e. Was en autopsy performed? 24b. Were autopsy findings eveilable prior to Completed brovair lar disease completion of cause of death? page 2 1 Yes 2 No 1 Yes 2 No Witai 25. Was case referred to medical funeral director Be 26. Plece of Deeth (Check only one) To. Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpetient 3 DOA Division of 28a. Date of Injury (Month, Day Year) 27. Mennes of Deeth 28c. Injury et Work? 28d. Describe how Injury occurred 28b. Time of or Attending 1 Naturel 5 ☐ Pending deeth. 1 Yes 2 No investigetion 2 Accident eftar deet Director: 6 Could not be determined 3 Suicide Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours e Hospital 29a. Certifier 11G Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and dua to the cause(s) end menner es stated Medical completaly Medical Examiner: On the basis of axaminetion end/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and manifer stated. (Check only one) within 2 To the the 29d. Dale signed (Month, Day, Year) 29b. Signature at 29c. License number erson who completed cause of death (Item 23e) (Type, Print) and eddress of th Day, Year) strar's Signature Registrar **DHMH 16 Rev 6/95** 



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State of Maryland / Department of Health and Mental Hygien ( Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** Ashley Greta Veronica 07 1231pm 17 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Prince Prince Georges Center Georges Hospital Chever 14 Months Days Hours Min. 3. Date of Birth (Month, Day, Year)

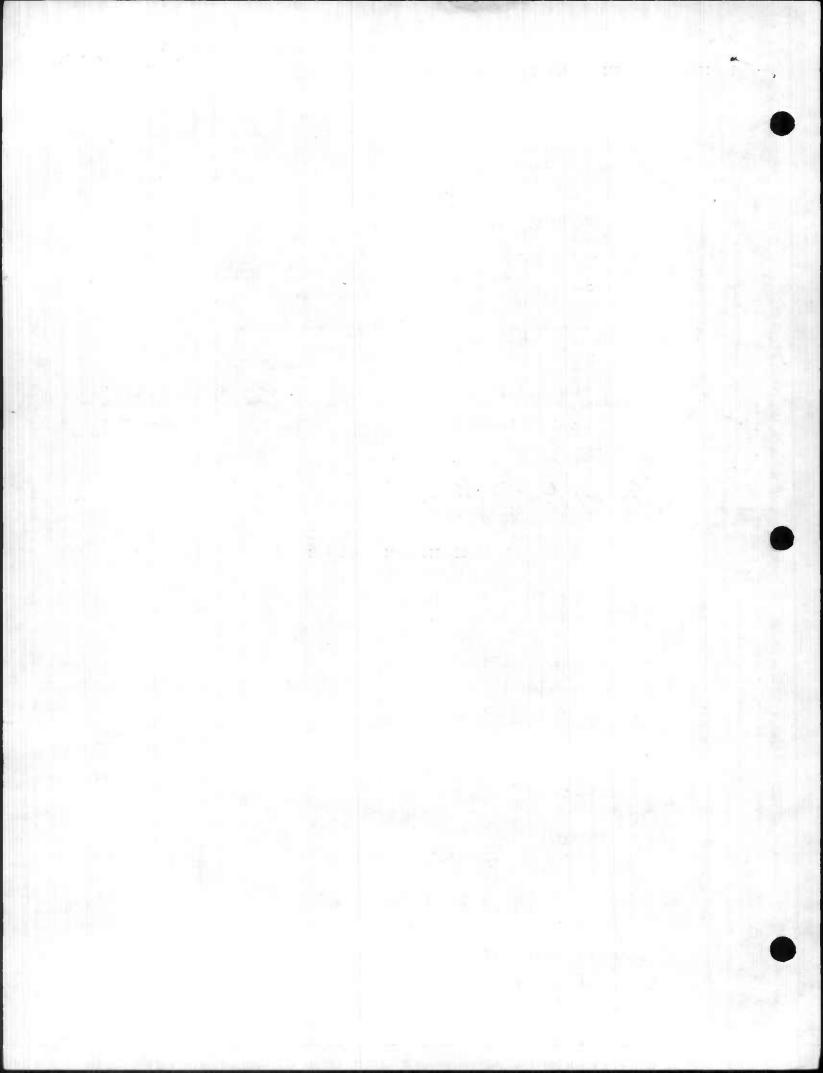
Jan 13, 1936 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 200 F 63 Yes. NA Director Jamaica Usual Residence of Decedent 10a. Stata 10c. City, Town or Location 10d. Inside City Limits than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at WI Jamaica Clarendon 1 D∛yes 2 DNo Director 10f. Zio Code 10e. Street and Number 10g. Citizen of What Country? 9 Williams Avenue NA Funeral Jamaica filed within 72 hours after death 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Meritel Status 1 Yas 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Merried 21215-0020 1 Yes 2 No Specify: Black. Specify: à 3 →Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) unk Hospital Housekeeper Baltimore, Maryland permit. Pages 1 and 2 should be fits Department of Health and Mental Hy Important: If Item 27 is marked other only Injury or other treumatic event 17. Fathar's Neme (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unk unk 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5504 63rd Avenue, Riverdale, MD 20737 Rupert Henry - Son 20b. Place of Disposition (Name of 20e. Method of Disposition 20c. Location - City or Town, Steta cemetery, cremetory or other place) 1 ☐ Burial 2 ☐ Cremetion 3 ♣ Removel from Stete 7/24/99 Jamaica, WI unk 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Name and Address of Facility R. N. Horton Co. Morticians, Inc. Souton 600 Kennedy Street, N.W., Wash., DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final Pulmonary embol diseese or condition resulting in death) **Examiner** Due to (of as a consequence of): or Attending Physician: The law requires that the death certificate be executed and Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseasa or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical the the Due to (or as a consequence of): Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? detach 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 K Unknown signed by Hypotension þ Records, should be 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? Seizure disorder Kenal 1□ Yes 2DNo 1 Yes 2 No certificate insufficiency Division of Vital funeral director, Be 25. Wes casa referred to medical exeminer? 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) Medical Certification: To 1 Yes 2 No this 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 27. Menner of Death 28d. Describe how injury occurred 28b. Time of After 5 Pending 1- Natural 1 Yes 2 No death. investigetion 2 Accident after death 6 Could not be determined To the Hospital or Atte within 24 hours after del To the Funeral Director completely filled in by the 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 | Homicide 29a. Certifier t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29b. Signature end title of certifiqu 29c. License number 29d. Date signed (Month) Day, Year) eve 30. Numeral address of person who completed cause of ceath (Item 23a) (Type, Print) Drive Cheverly, MD 20785 3001 Hosp, tal Cate venis lames 32. Registrer's Signature 31. Date filed (Month, Dey, Year) State Serena 21 Registrar



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1 Never Men	ried 200 Merried 4 Divorced	1 ☐ Yes 21 N If Yes, Give Yeer or Detes:	0	1 Yes 2 No		o moan, etc.)		Black	
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resulting in death)	Last	d	nue to (or es e conse	quence or).				1	1.79
	ficant conditions of	contributing to death bu	t not resulting in the	underiving cause g	iven in Pert I.	23b. Did	tobacco use co	ntribute to the	cause of death
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Registrar DHMH 16 Rav 6/95



#### Please Type or Print In Black Indelible Ink. Assu. All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Month Dev 9:08 AM 17, ARMORE SIDNEY J. JULY 1999 4c. County of Death 4e Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death SUBURBAN HOSPITAL BETHESDA MONTGOMERY 6. Sex 10 M 2 F 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) Days Months Hours SEPTEMBER 6, 130-12-6189 1914 NEW YORK Usual Residence of Decedent 10d. Inside City Limita 10a. State 10b. County 10c City Town or Location 1 Yes 2 No MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6111 MONTROSE ROAD #726 20852 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) STATISTICIAN FEDERAL GOVERNMENT 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) BENJAMIN AREMOWITZ SARAH JACOBS 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stele, Zip Code) 19a. Informant's Name/Relationship (Type, Print) CAROL ANN SHERMAN (NIECE) 9709 HOLLOWAY HILL COURT POTOMAC MD 20854 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Buriai 2 ☐ Cremetion 3 ☐ 1 4 □ Donation 5 □ Other (@ KING DAVID MEMORIAL GARDENS 7/19/99 FALLS CHURCH VA 21. Signature of Funeral Service 22. Name end Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS INC. 1170 ROCKVILLE PIKE ROCKVILLE MD 20852 Approximate 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart layure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or es e consequenca of) Due to (or as a consequence of): 23b. Did tobacco usa contributa to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yea 2 ☐ No 1 Yes 2 No 26. Place of Death (Check only one)

**Physician** /Medical Examiner

Physician/Medical

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Completed

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Medical

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ARMOR

Box 68760

Records,

of Vital

Division

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Director:

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Physician

/Medical

Examiner

**Funeral** 

Director

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Department of Health Important: If Item 27

Maryland 21215-0020

Directo MD

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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last

Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? Hospital: 1 Yes 2 No 1 Inpatient

27. Manner of Death

5 Pending investigation 6 Could not be

28a. Date of Injury (Month, Dey Year)

2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

The MD 20852

29a. Certifie (Check only one)

1 DNatural

2 Accident

3 ☐ Suicide

4 Homicide

1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. License number

29b. Signeture and title of certifier

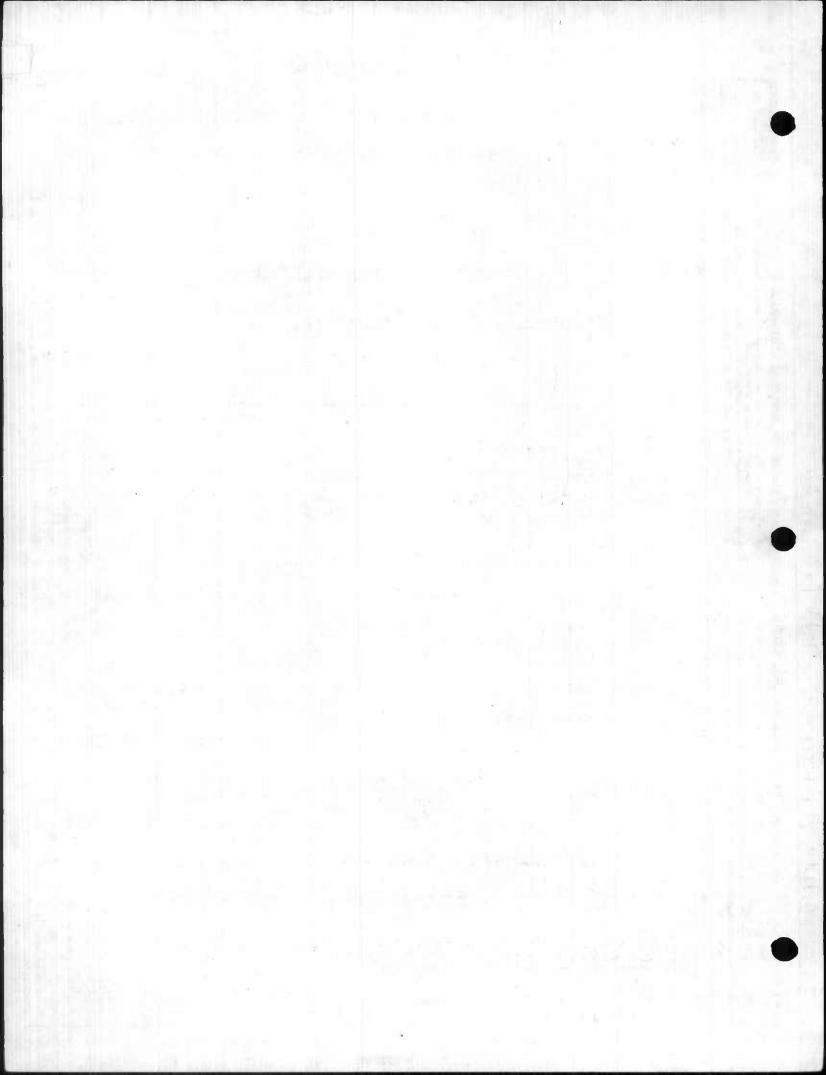
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29d. Date signed (Month, Day, Year)

State Registrar

31. Date liled (Month, Day, Year) 32. Registrer's Signature 9

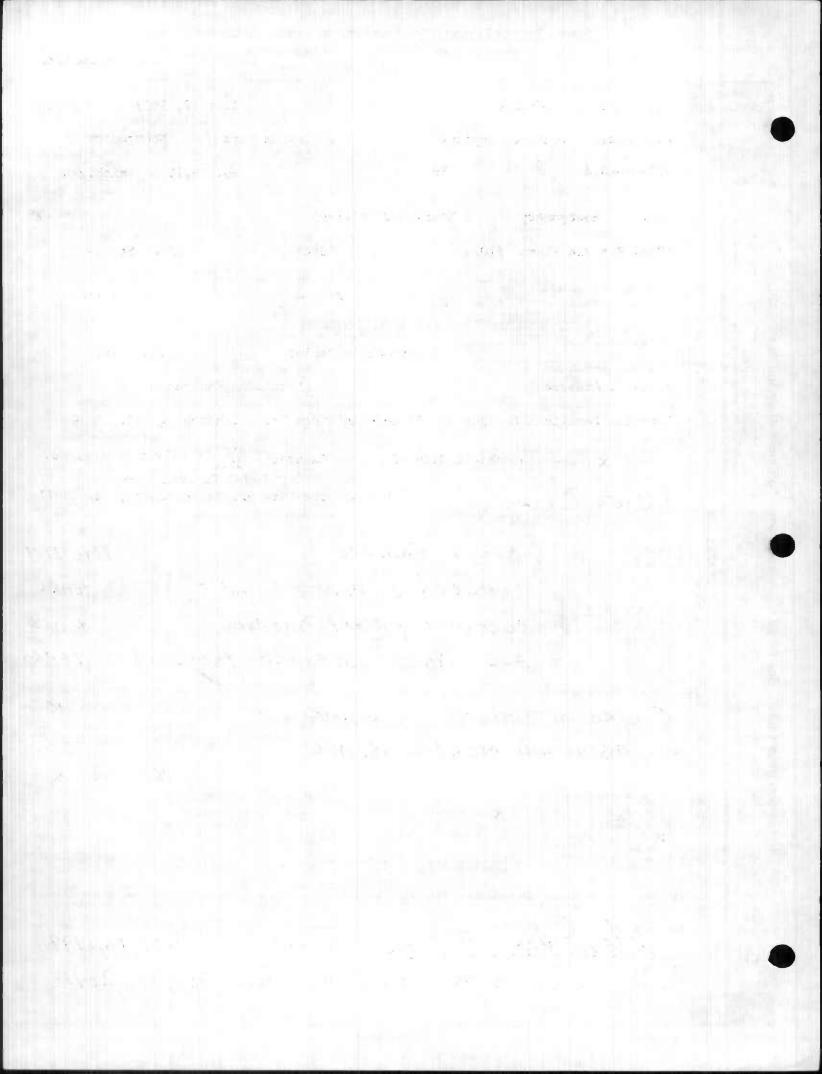
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



## Please Type or Print in Biack Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 3 9 24275

				Ce	rtificate	of Dea	ath		Reg. No.			
	1. Decedent's Name (First, Mi	ddle, Last)			7.1			2. Dete of De Month		Vans	3. Time of Dea	ath
Physician · /Medical	Niels Peter	Andersen						July	17, 199	9 Year	1:00p	m
Examiner	4a Facility Name (If not institu							Location of Deat	4c. Cour	nty of Death		
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Funeral Director	5. Social Security Number 097–07–4016	6. Sex 1 M 2 □ F	7. Age (In yrs. la 96	rst birthday) Yrs.	Months D		Inder 24 Hrs ours Min.	8. Date of Bir (Month, Da Feb. 1	th ly, Year) 9,1903	Cou	olace (Stata or Fo ntry) higan	reign
pue M.	Usual Rasidence of Dacedent 10a. Stete 10b. Cou	nty	10c. City,	Town or Lo	ocation						10d. Inside City L	imits
natural, or itema 23a or 28a-f ahow act all Examiner must be notified at each by Funeral Director		tgomery	Mon	tgome	ry Vill						1 Yes 2	No
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at, or items 23s or 28s-f show Exercitive trust be notified at by Funeral Director	11. Meritel Status  1 □ Never Married 2 □ M 3 ☼ Widowed 4 □ Divord	Armed For	2 No		Was Deceden If Yes, specify 1☐ Yes 2∯			specify Yes or No to Ricen, etc.)	Spec	ace - Americ leck, White, city: Wh		
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am 2	20a. Method of Disposition	clicki (Dau	20b. Pla	ce of Dispo	sition (Name	of	DI.	Data	20c. Location			
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Important: h any injury o page.	21. Signature of Funeral Servi	ce Licensee						eVol Fun Dr. Gai			d. 20877	,
	23a. Part1. Enter the disease shock, or heart failure. I	or complications that ca	used the death.							1	Approximate Interval Between	
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the buriel-transit	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	. COR	ONARY	as a consec	RIGR	y D	ISEA	SE			YEAR	5
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certificate he rector, page	25. Was cese referred to med	cel				26	Place of De	ath (Check only		1	_ 100 Egs(110	
To B	axaminer? 1 ☐ Yes 2 <b>☑</b> No	Hospital:	patient 2 E	R/Outpatie	nt 3 DOA	Other		lome 5 ☐ Resi		Other (Specia	(v)	
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	30: Name and address of pers	on who completed cause		-40		1 .	-	D	0.4	10	0010	
State	SAMIR NGA 31. Date filed (Month, Day, Ye		76/0	. , ,	ROLL	AV.	, IAK	OMATA	RK, M	10/2	0912	
Registrar	JUL 2	1999   🗡	epera	9.	do	Us/						



#### Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3 Time of Death Month JULY 19 1999 2052 4b. City, Town, or Location of Death 4c. County of Death ARUNDEL CENTER ANNAPOLIS If Under 1 Yaar | If Under 24 Hrs. 7. Age (In yrs. lest birthday) Birthpiece (State or Foreign Country) Months Days Hours ON M 2D F Yrs. 48 NOV. 5 1950 D.C 10b. Count 10c. City, Town or Location 10d. Inelde City Limits ANNAPOLIS 1 Yas 2000 10f. Zip Code 10g. Citizen of What Country? 21403 US 12. Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian. Biack, White, etc. 1 Yas 2 No If Yes, Give Yaar or Datas: 1 ☐ Yas 2 No Specify: Specify: BLACK 16b. Kind of Business/Industry

1. Decedent's Name (First, Middle, Last) **Physician** LONNIE W. ALLEN /Medical 4a Facility Name (If not institution, give street end number) Examiner ANNE ARUNDEL MEDICAL 5. Social Security Number **Funeral Director** 215-50-8956 Usual Residence of Decedent the Menylend 10a State r 28a-f ehow MARYLAND ANNE ARUNDEL Directo 10e. Street and Number with 7 is marked other than "naturel", or items 23a or treumstic event, the Medical Examiner must be a 3522 ROCKWAY AVENUE Pages 1 and 2 should be filed within 72 hours efter deeth nent of Health and Mental Hygiena. Int: If Item 27 is marked other than "naturel", or Items 23: Funeral 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 p 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MD. DEPARTMENT OF Eiementery/Secondary (0-12) College (1-4or 5+) HOUSING & COMMUNITY HOUSING REHABILITATION 12th 17. Father's Name (First, Middle, Last) DEVELOPMENT OFFICER 4 yrs. 18. Mother's Neme (First, Middle, Be ARIS T. ALLEN FAYE WATSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 3522 ROCKWAY AVE. ANNAPOLIS, MD. 21403 VALERIE V. ALLEN (WIFE) 20b. Place of Disposition (Name of cematery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ŏ Department of Important: If eny injury or ANNAPOLIS MEM. GARDENS 7/26/99 ANNAPOLIS.MD. 4 □ Donation 5 □ Other (Specify) 22. Nama and Addrass of Facility 21. Signature of Funeral Service Licensee WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrast shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Deeth Physician Immediate Cause (Final disease or condition resulting in death) /Medical **Examiner** Examiner physician end the bunal-transit that the death cartificate be axecuted Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, perterated 9 voder Physician/Medical Due to (or as a consequence of) 98 esn 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 3 Probably 4 Unknown 1 Yss þ 24b. Were autopsy findings

page 2 s

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Completed Be 2 Certification:

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signed by the a Hospital or Attending Physician: after death lilled in by • Funeral npletaly To the Vithin 2

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								1 🗆 Yes	2 No	1 ☐ Yas 2	No
	Wes case refer					26. PI	ece of Death (C	heck only one)			
	examiner?	No	Hospitai: 1 Inpatient 2	☐ ER/Outpatient	3 🗆 D	OA Other: 4	Nursing Home	5 Residence	8 Other	(Specify)	
-	Manner of Deetl  Ratural  Colored  Accident	5 Pending investigation	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury	м	28c. injury et Work? 1 ☐ Yes 2		Describe how in	njury occurre	d	
	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At building, etc. (Spe		et, facto	ry, office	28f.	Location (Street City or Town, St	t and Number tete)	r or Rural Route N	lumber,
29e	Certifier		ysicien: To the best of my k								20(2)

end manner steted

29c. License number

29b. Signature and title of certified

29d. Date signed (Month, Dev. Year)

24a. Was an autopsy

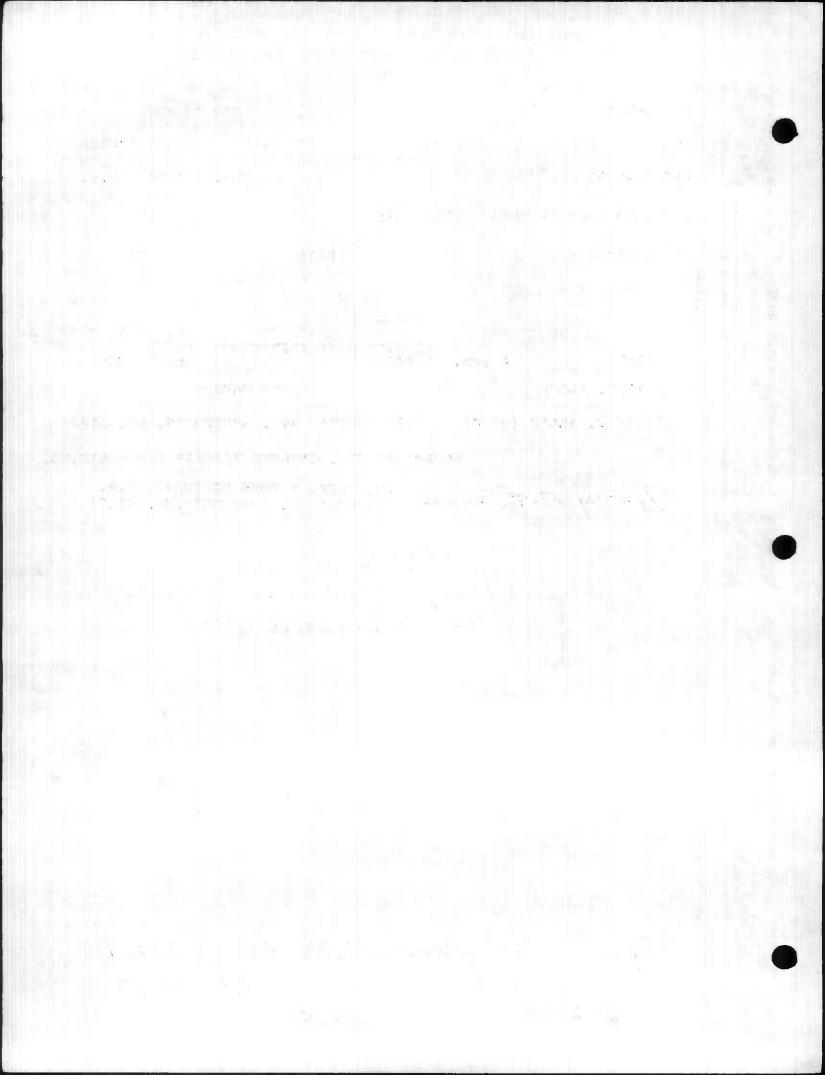
30. Name entitleddress of persor who completed cause of deeth (item 23e) (Type, Print)

Ridgely Ave#222

State Registrar

Jerrih 31. Date filad (Month, Dey, Year) JUL 23 1999 32. Registrar's Signature

600



#### Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 2. Data of Death 1. Decedant's Nama (First, Middla, Last) Florine R. Brice July 17, 1999

If Under 1 Year

Days

7. Age (In yrs. last birthday)

10c. City, Town or Location

83

6. Sax 1 ☐ M 2 ☐ F

10b. County

4b. City, Town, or Location of Death

Takoma Park

If Under 24 Hrs. Hours Min.

Hours

3. Tima of Deeth

11:00 AM

Birthplece (State or Foraign Country)

Washington, D.C.

10d. Insida City Limits

4c. County of Death

July 21,1915

Montgomery

**Physician** \* /Medical 4e Fecility Nama (If not institution, give street end number) Examiner Washington Adventist Hospital 5. Social Security Number **Funeral** 577-60-5504 Director Usual Rasidance of Dacedant tem 27 is marked other than "natural", or thems 23s or 28s-f show other traumstic event, the Medical Examiner must be notified at To Be Completed by Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after deal. Department of Health and Merial Hygiens. Important if filem 27 is marked other the sany injury or other traument. Physician /Medical Be Completed by Physician/Medical Examiner and Division of Vital Records, P.O. Box 68760,

signed by the attending physician d be detached for use as the buna After this certificate has To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica

N/A N/A	Wa	shingto	n, D.C.				14 Yas 2
10e. Street and Number			10f. Zip Code		10	g. Citizan of V	Vhet Country?
322 Missouri Aver	nue N.W.		2001	.1		United	States
11. Meritel Status  1 Never Married 2 Married  3 Widowad 4 NDivorced	12. Was Decedant Ever in U. Armed Forcas? 1 ☐ Yas 2∑ No If Yas, Giva Year or Datas:		is Decedant of as, specify Cu Yas 200 No	Hispanic Orlgin? (S ben, Maxican, Puar Specify:	Specify Yas or No- to Rican, etc.)		e - Amarican Indian, ek, Whita, etc.
15. Decedant's Ed	ucetion		nt's Usual Occi	upation a during most of wo		16b. Kind of Bu	usiness/Industry
(Specify only highest gra- Elementary/Secondary (0-12)	College (1-4or 5+)	lifa. DC	NOT usa ratir	re Assista		II.S. G	Government
17. Fathar's Nama (First, Middla, Last) Howard Brice	2				ma (First, Middla, N		
19a. Informant's Name/Ralationship (7					ural Routa Number,		
William Davis, br				reet N.W.			o.c. 20011
20e. Mathod of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☒ Othar (Specify	Ramoval from Stata	lece of Disposit ematary, crema	tory or othar p				City or Town, State  Maryland
21. Signature Funeral Sovice Licen			Nama and Add		1/23/99	Laurer,	Maryland
MAAAA)	MALA	// Mc	Guire E	uneral So	ervice, I	nc.	n D C
ant1. Enter the disease, or comp shock, or haart failura. List only	plications that ceusad tha daatl	h. Do not enter	the mode of dy	/Ing, such as cerdia	c or raspiratory arre	st,	Approximeta Interval Between
Immediate Cause (Final	Dr. and Marie	1110					Onsat and Death
disease or condition resulting in death)	· Meymo	ras a conseque	ance of):				, wan
_	Rectal	Can	cek				1 year
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dua to (o	r as e conseque	ence of):				4
Cause (Disease or injury that initiated events resulting in death) Last	Due to (or	r as e consequa	nca of):				
	d						
Part II. Other significant conditions or	ontributing to death but not res	ulting in the und	erlyin <i>g</i> ceusa (	given in Part I.			ntributa to the causa of dea 3 ☐ Probably 4 Ûnkn
					24e. Was er perform		24b. Ware autopsy finding available prior to completion of cause
					1 □ Ya	s 20 No	of death?
25. Was case referred to medical				26 Place of De	ath (Check only on		
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 XInpatient 2	EB/Outnationt	3 DOA	Mb in a	Homa 5 ☐ Raside		er (Specify)
27. Manner of Death  1 Natural 5 □ Pending 2 □ Accident investigation	28a. Data of Injury (Month, Day Year)	28b. Time of Injury	28c. Inj W		28d. Describe ho		
3 Suicide 6 Gould not be determined	28e. Place of Injury - At he building, atc. (Specifical Control of the Control of	ome, farm, strea	f, factory, offic	8	28f. Location (Str City or Town		er or Rural Routa Number,
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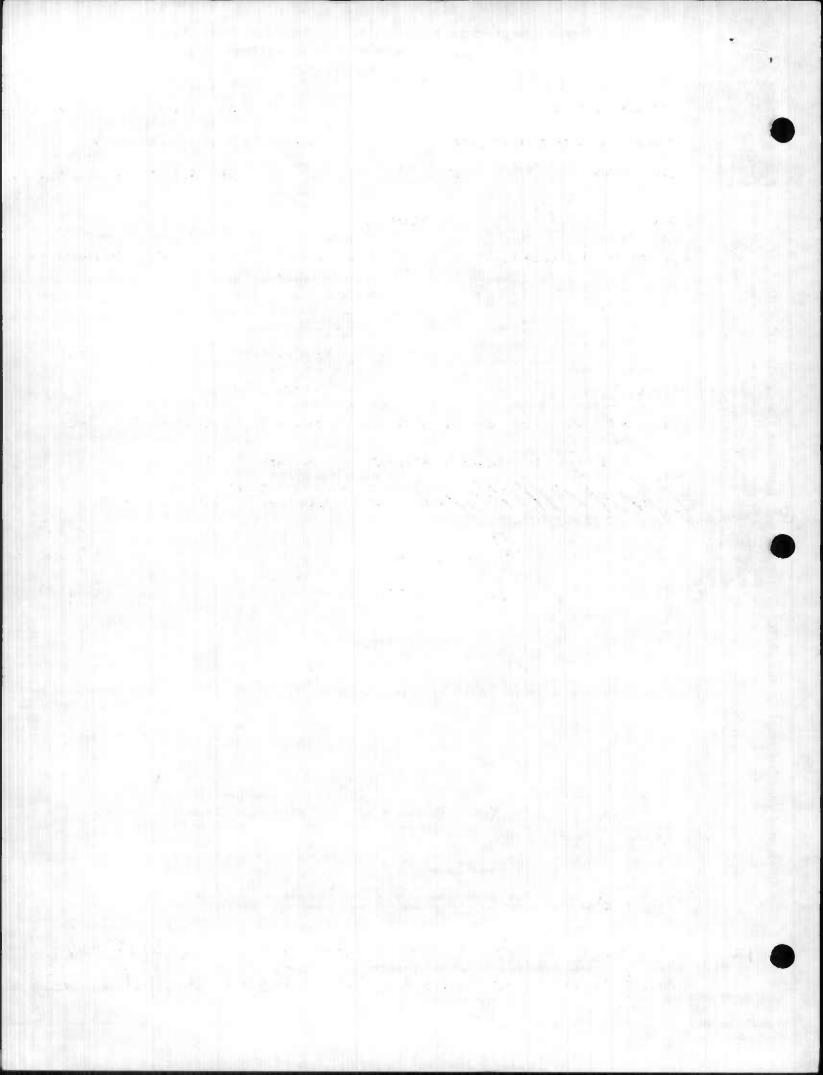
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State Registrar 31. Data filed (Month, Day, Year)

23 1999

32. Registrar's Signatura

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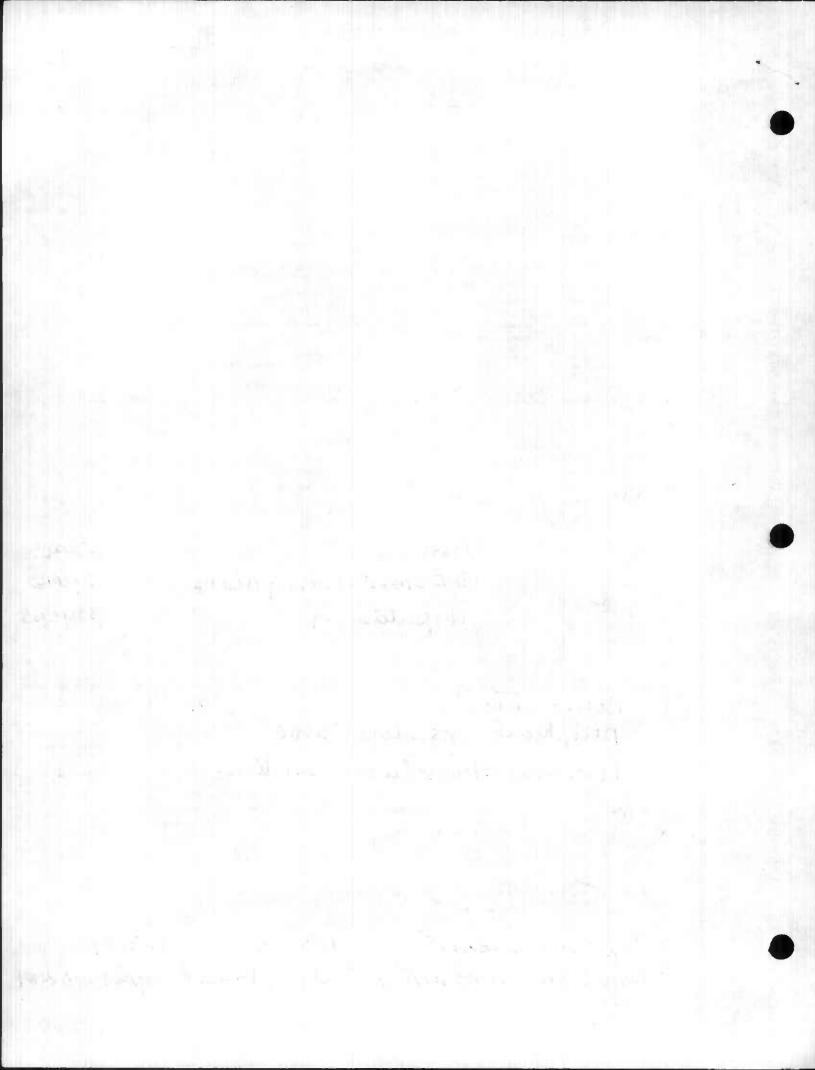
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State of Maryland / Department of Health and Mental Hygiene Q Q 21, 278

•			Certificate of	Death	Reg. No.	24210
Dharatalan	1. Decedent's Neme (First, Middle, L.	ast)		2. Date Mo	e of Death	3. Time of Death
Physician /Medical	KILA	Bis	acquino		July 14, 19	
Examiner	4a Facility Neme (If not Institution, gi			4b. City, Town, or Location of	of Death 4c. County	of Deeth
70 L	Spa Creek Nurs		: last hirthday) If Under 1 Yes	Annapolis		Arundel
Funeral Director	053-18-7253	Sex 7. Age (In yrs 76	Months Dave	s Hours Min. (Mo Ma)	e of Birth nth, Day, Year) 7 20, 1923	9. Birthplace (State or Foreign Country) Bronx, NY
2	Usual Rasidence of Decedent  10a. Stete 10b. County	10c. C	ity, Town or Location			10d. Inside City Limits
a Maryl Mel sho diffed a	MD Anne A	rundel	Annapolis			1 ☑ Yes 2 ☐ No
er death with the Maryla harms 23a or 28a-f shoo ner must be notified at 'uneral Director		e	10f. Zip Code 21	403	10g. Citizen of V	What Country?
	3 ☑ Widowed 4 ☐ Divorced	12. Wes Decedent Ever in I Armed Forces? 1 Yes 2 N No If Yes, Give Year or Dates:	U.S. 13. Was Decedent of If Yes, specify Cu	Hispanic Origin? (Specify Yeban, Mexican, Puerto Rican, eps. Specify:		e - American Indian, ck, White, etc. White
72 ho 72 ho fical fical	15. Decedent's E (Specify only highest gi	ducation	16a. Decedent's Usual Occ	upation e durina most of workina	16b. Kind of Bu	usiness/Industry
Maryland 21215-0020 52 should be filed within 72 hours at h and Mental Hygens. 7 te marked other than "natural", or traumatic event, the Medical Exam To Be Completed by 1	Etementery/Secondery (0-12)	College (1-4or 5+)	Legal Secr	ed)	Law 0	ffice
Be C Be C		)		18. Mother's Name (First,	Middle, Maiden Sumer	10)
Menta Menta Mile and		a		Elena Farí	one	
and s	19a. Informent's Name/Reletionship	(Type, Print)	19b. Mailing Address (Street	et and Number or Rural Route	Number, City or Town,	State, Zip Code)
- 5905	Thomas Bisacquine  20e. Method of Disposition  1 Durlel 2 Cremelion 3	20b.	12020 Rose Place of Disposition (Name of cometery, crematory or other pi	Hall Drive Cli		inia 20124 City or Town, Stete
altimore mit. Pages 1. partment of He portant. If Her I figury or oth	4 Donation 5 Other (Special		ate of Heaven	Cemetery 7/17	7/99 Mt. P.	leasant, NY
permit Depart Import any in	21. Signature of Funeral Service Lice	nsee	22. Name and Add Capitol	Funeral Servi	ce, Inc.	Virginia 22046
	28a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused the dea	ath. Do not enter the mode of d	ring, such as cardiac or respir	atory arrest,	Approximate Interval Between
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/Medical	Immediate Cause (Finel disaase or condition	(1/12	min			5days
Examiner	resulting in deeth)	Due to (	(or as a consequence of):			
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cate be executed physician and is the bunal-transit edical Examiner		Due to (	or as a consequence of:	$\cap$		30 years
# 5 5 S	that initiated events resulting in death) Lest	Due to (d	or as a consequence of):			
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that the red by the detache		stenosis	\$		10XY•• 2□ No	3 Probably 4 Unknown
HECOTGS, It he law requires that has been signed ge 2 should be de ordered by F			sculudi		a. Wes an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
- F # 2 0	Ceron	one stud	osclewich	reart disense	2_1□ Yes 2□XNo	1 ☐ Yes 2X No
Physician: The Physician: The cartificate ral director, par. To Be Co.:		Hospital:	10	26. Place of Death (Chec		
그 일을 수 되		1 Inpatient 2	JENOURPHIER 3LI DON	4LANursing Home 51	☐ Residence 6 ☐ Oth escribe how injury occur	
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than deat deat ctor:	2 Accident investigett 3 Suicida 6 Could not t 4 Homloide determined	08 Dines of Injury At h	home, ferm, street, factory, offic	e 28f. Loc	cation (Street and Numb y or Town, Stete)	per or Rural Route Number,
Hospi 24 hou Funer tely fill	29e. Certifier 1 Certifying Pi	miner: On the basis of examina	owledge, death occurred at the ation and/or investigation, in my			
within 2 To the comple	ane)  29b. Signeture and title of certifier	and manner stated.	20c Line	nse number	29d Date signe	d (Month, Dey, Year)
8 4 8 4	M. CO.				7/10	ulaa.
6	30. Name and address of person who	completed cause of death (ite	m 23a) (Type, Print)	108314 108314	2 1	1199
State	31. Dete filed (Month, Dey, Year)	BUANTS I		edgely Du	C. ANNAY.	alis, mb 21801
Registrar	JUL 19 19	99 Seneva	D. Spark	2		

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show 288-1 b Nerns 23a 72 hours after b "natural", Hygiene. Pages 1 and 2 should be nent of Health and Mental Department of Health, Important: If Nem 27 Is any injury or other tra

Baltimore, Maryland 21215-0020

**Physician** /Medical Examiner

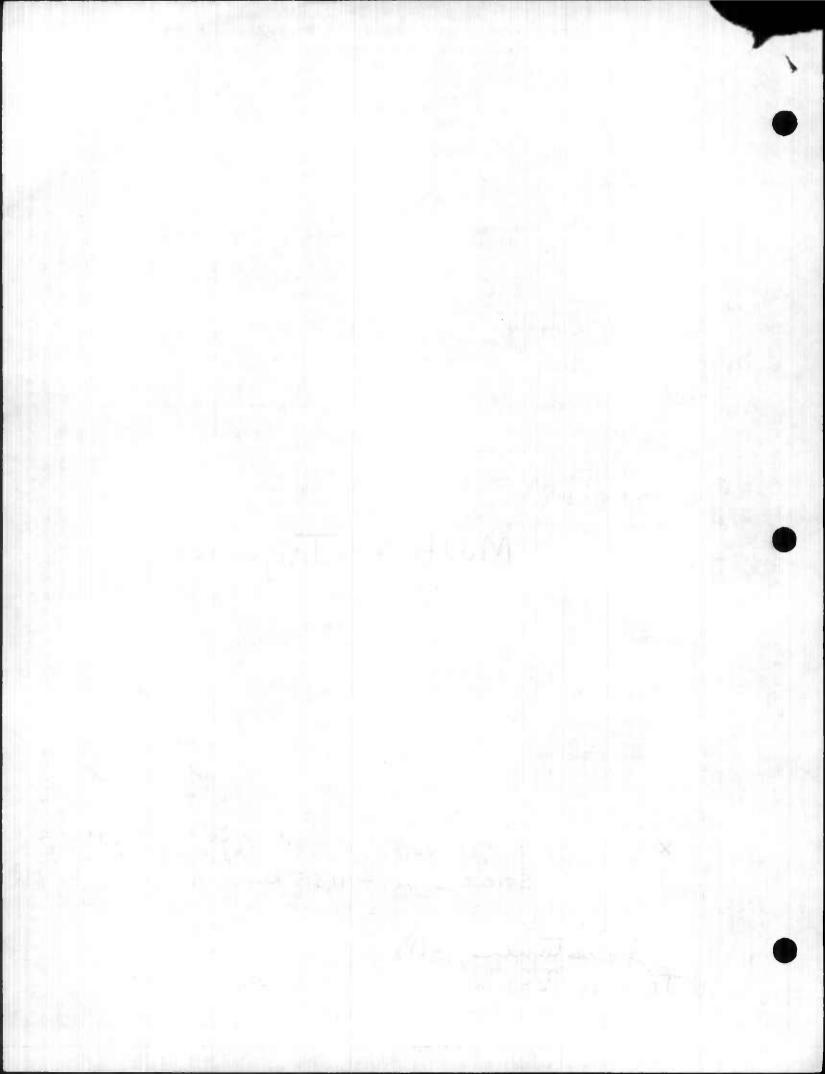
sician and buriaf-transit The law requires that the death certificate be executed physician s the buria Box 68760 US0 1 Records, P.O. signed by t Division of Vital Physician: this or Attending death. s after death 3 filled in 24 hours

EDWARD BARTLETT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 0230 AM Month Dev Yeer Edward Bartlett JULY 16, 1999 4e Fscility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SUBURBAN HOSPITAL BETHESDA MONTGOMERY 8. Dete of Birth (Month, Day, Year) NOV 17, 1947 If Under 1 Yeer If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. lest birthday) 9. Birthplece (State or Foreign 1₩ 2□ F Months Deys Hours Country)
Buffalo, NY 634-18-9098 51 Usual Residence of Decedent 10a, Stete 10c. City. Town or Location 10b. County 10d. Inside City Limits 1 Ves 2 □ No Directo Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11311 Woodson Avenue 20895 USA Funeral 12. Wes Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian. Bleck, Whita, etc. 1 X Yes 2 □ No If Yes, Give 1 Never Msrried 2 Merried 1 Yes 2 No Specify: Specify: þ 3 Widowed 4 X Vivorced White Yeer or Detes: Vietnam Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Owner / Operator Computer Software 17. Father's Name (First, Middle, Last) 18. Mother's Nema (First, Middle, Meiden Sumeme) Be Burdette Bartlett Florence May Harbeck 19e. Informent's Neme/Reletionship (Type, Print) (Sister) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8943 W. Manzanita Dr. Peoria, AZ 85345 Gail M. Bartlett - Murray 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stata 1 ☐ Buriel 2 M Cremetion 3 ☐ Removel from Stete Metropolitan Crematory 7/19/99 Alexandria, Virginia 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signsture of Funerel Service Licenses 22. Neme end Address of Fecility Metropolitan Funeral Service, Inc. 5517 Vine Street Alexandria, VA 23a. Perry. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, speck, or heart failure. List only one cause on each line. Approximete triterval Between Onset and Deeth immediete Cause (Final diseese or condition resulting in deeth) sequence of): Examiner Sequentially tist conditions, if sny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or es a consequence of) Physician/Medical Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use centribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown þ 24e. Was en eutopsy performed? 24b. Were sutopsy tindings evailable prior to Completed completion of ceuse of death? 2 No 1 ☑ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Piace of Deeth (Check only one) To Other: 4 Nursing Home 5 Residence 6 Other (Specify) ¥es 2□ No No Pedestrium Street
Pedestrium Street
Pedestrium Street
281. Lécation (Street end Number or Rurel Route Number,
City or Town, Stete)
Woodson Ave Kensmyton 27. Menner of Deeth 28a. Dete of Injury (Month, Qay Year) 28b. Time of tnjury 28c. Injury at Work? Certification: 1 Neturel 5 Pending investigation 1 Yes 2 No 2 Accident
3 Suicide 1215 6 Could not be determined Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 286 4 ☐ HomicIde 11315 reet 0+ 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated)
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. awn edical 29e, Certifier (Check only one) 29d. Dete signed (Month, Day, Year) 29b. Signeture end titl of certifier 29c. License number O.C.M.E. 17, 1999 JULY fress of person who completed cause of death (Item 23a) (Type, Print) estance 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month) Dev. Year)
JUL 2 3 1999 32. Registrer's Signeture

State Registrar

within 2.

the



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygier.

Certificate of Death 1 Decedent's Name (First Middle Last) 2. Deta of Deeth 3. Time of Death Month **Physician** MATTIE BEASLEY 5:58 pm JULY 18 1999 /Medical 4a Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 831 BESTGATE ROAD ANNAPOLIS ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 F Vrs 273-24-8634 Director JULY 20 1916 KENTUCKY 82 Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryt 1 Yes 2 No MARYLAND ANNE ARUNDEL A MAPOLIS Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code than "natural", or items 23a or the Medical Examiner must be r 831 BESTGATE ROAD 21401 Funeral US 13. Was Decedent of Hispanic Origin? (Specity Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Meritel Stetus hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 Specify: BLACK 1 ☐ Yes 2 No þ 3 Widowed 4 Divorced Completed 15. Decedant's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry UNIVERSITY OF Elementary/Secondery (0-12) Collage (1-4or 5+) CINCINNATI 9th HOUSEKEEPING 17. Fethar's Nema (First, Middla, Last) 18. Mother's Neme (First, Middle, Maidan Sumame) 1 and 2 should be lealth and Mental JOHN BEASLEY merked LIZZIE BLYTH 19a. Informent's Neme/Ralationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stata, Zip Code) . MAURIENE NOLAND (COUSIN) 2417 WEAVER ST. DAYTON, OHIO 45408 f Health flam 27 i 20b. Pleca of Disposition (Neme of cametery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition Pages 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 7/23/99 ANNAPOLIS, MD. ANNAPOLIS MEM. GARDENS 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensee 22. Name end Address of Fecility 2020 WM. REESE & SONS MORTUARY, P.A. 23a. Pert1. Enter the disasse, or complications that caused the deeth. Do not after the mode of dying, Such as cardiac or espiratory area. MD . 214 Opproximete shock, or heart teilure. List only one ceuse on each line. Onset and Death Physician Immedieta Causa (Finel disease or condition resulting in daeth) /Medical **Examiner** Examiner physician and s the bunal-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Box 68760, Physician/Medical SE 080 P.O. Pari II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Division of Vital Records, p 24b. Wera autopsy findings eveilable prior to complation of cause of death? 24e. Wes en eutopsy performed? Completed peen pege 2 certificate hes 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes casa referred to medical exeminer? 26. Plece of Deeth (Check only ona) Be To Othar: 4 Nursing Home 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Aesidenca 6 Other (Specify) this funeral 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation Attending 1 Natural after death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stele) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) in 24 hours the Funeral Director filled in br 4 Homlcida ö Hospital 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the ceuse(s) and menner as stated. edical completely 2 Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, daeth occurred at the time, dete end place, and due to the causa(s) end,menner stated. (Check only within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30 Name and addrass of person who complated gauss of daeth (term 23e) (Type, Print)

LAND, S 6000 Ridgely HVB 32. Registrer's Signature 31. Dete tiled (Month, Dey, State 1999 Registrar

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#### Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death JUL 1999 8:10 AM 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street and number) 4c. County of Deeth Baltimore Hospital Hopkins Johns NONE 7. Age (In yrs. last birthday) If Under 1 If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) MARCH 24 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) Days 1₩ 2□ F Yes 1987 MARYLAND 216-17-9980 Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits MARYLAND ANNE ARUNDEL ANNAPOLIS 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 12 C BENS DRIVE 21403 US 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Bleck, White, etc. 11. Meritel Status Never Merried 2 Married 1 Yes 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) ANNAPOLIS MIDDLE STUDENT 6th 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) KENNTHE BRASHEARS SR. 19a. Informent's Neme/Reletionship (Type, Print) DARLENE HARROD 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stele, Zip Code) DARLENE BRASHEARS (MOTHER) 12 C BENS DRIVE ANNAPOLIS, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dete ANNAPOLIS MEM. GARDENS 7/19/99 ANNAPOLIS, MD. 1 Burial 2 Cremetion 3 Removel from Stete 4 Donetion 5 Other (Specify) 21. Signeture of Funerel Service Licensee 22. Neme and Address of Fecility WM. REESE & SONS MORTUARY, P.A. Javy 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear feiture. List only one cause on each line. Approximate Intervel Between Onset and Death Immediete Cause (Final disease or condition resulting in deeth) MULTIORGAN FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last PNEUMONITIS Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did lobacco usa contributa to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Was en eutopsy performed? Hemornayic 2 No 1 ☐ Yes 2 NO

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

10a. State

Completed by Funeral Director

8 0

**Funeral** 

Director

ahow

permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryle Department of Health and Mantel Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f ahov any Injury or other traumatic event, the Medical Examiner must be notified a DES.

21215-0020

aitimore, Maryland

Physician/Medical Examiner Be Completed by

or Attending Physician: The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

Medicai Certification: To

To the Hospital or Attendit within 24 hours aftar death. To the Funerel Director: A filled in by the

this in

State Registrar

31. Date filed (Month, Day, Year)

JUL 19

5 Pending investigation

6 Could not be

25. Was case referred to medical examiner?

27. Menner of Death

1. Maturel

2 Accident

3 Suicide

29e. Certifier (Check only one) 29b. Signeture and

4 Homicide

address of person who completed cause of deeth (Item 23a) (Type, Print) GUERGUERIAN 32. Registrar's Signature

Welley Picv Fellow

28a. Date of Injury (Month, Day Year)

Hospitel: Dempatient 2 ER/Outpatient 3 DOA

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28h Time of

HORKINS HOSPITAL

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner steted.

29c. License number

1 Yes 2 No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how Injury occurred

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29d. Date signed (Month, Dey, Year)

JUL 3 9 1999 John D. Frak

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** FRANCIS WOOD BAKEN 5:304 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Vantage House Columbia Howard If Under 1 Year 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 12 M 2□ F 218-09-0373 Director 86 June 30,1913 New Jersey Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at MD Howard Columbia 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21044 5400 Vantage Point Road, #809 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0020 1 Yes 2√ No Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry flied within 7 I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) pennit. Pages 1 and 2 should be filled with Department of Health and Mental Hygiens Important; If them 27 is married other that any injury or other traumetic aware the Electrical Electrician 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frank Weathun Baker Jenny Meisel 19e. Informant'a Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurat Route Number, City or Town, State, Zip Code) 5400 Vantage Point Rd., Columbia, MD 21044 Rose Baker/ wife 20b. Place of Disposition (Name of cemetery, crematory or other place) July16 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal Metro Crematory Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funeral Service Line 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park F.H. 495 Gov. Ritchie Hwy., Severna Park, MD 21146

Approximate on each line.

Approximate Approximate Interval Between Onset and Daath Physician mediate Cause (Final lease or condition juding in death) Seedalon MAI GNANT Anhy Flein Due to (or as a consequence of): /Medical ONGESTIVE Heart Filare Months Exami Due to (or as a consequence of) Corovery Astring 68760 Physician/Medical Due to (or as a consequence of): å Hech moun Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 No 3 Probably 4 Unknown of Vital Records, ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? Completed 1 Yea 20 No 1 ☐ Yes 2 ☐ No 88 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) To Other: DMIrsing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

1 Yes 20 No 27. Manner of Deat

5 ☐ Pending investiga 2 Accident 6 Could not be 3 Suicide 4 Homicide

28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No 28d. Dascribe how injury occurred

28f. Location (Street and Number or Rurat Route Number, City or Town, State)

Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and fitte of certif

290-License number

Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gerenz. 1 HERRY 31. Date filed (Month, Day, Year) JUL 1 6 1999

State Registrar

Certification:

edical

29a. Certifier

**DHMH 16 Rev 6/95** 

Division

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6 Hospital

4 hours after death funeral Director.

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#### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2 Date of Death **Physician** Boardky tu gene 1999 08:25 10 /Medical 4a Facility Neme (If not Institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Annapolis Arunde Medical Center If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 6. Sex Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthday) **Funeral** 1 XM 2 ☐ F Months Days Yrs. 217-07-5697 **Director** 89 APRIL 20 1910 MARYLAND Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Herra 23a or 28a-f show line; must be notified at Yes 2 No MARYLAND ANNE ARUNDEL CHURCHTON Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 5605 BOARDLEY DRIVE Funeral 20733 US 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedant Evar in U,S. Armed Forces? 1 Yes 2 No If Yes, Giva 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ò 1 ☐ Yes 2 No Specify: Maryland 21215-0020 Specify: BLACK à 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry PRINCE GEORGE CO. Hygiens. Elamentery/Secondery (0-12) College (1-4or 5+) PUBLIC SCHOOLS 6th 0 CUSTODIAN other 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fethar's Neme (First, Middle, Last) Be Pages 1 and 2 should be of Health and Montal Nam 27 is marked o MATTIE ROBERTS JOHN C. BOARDLEY 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5605 BOARDLEY DR. CHURCHTON, MD. 20733 BERNICE BOARDLEY (WIFE) altimôre, 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Removal from State BELLVILLE CEMETERY 7/19/99 PORTSMOUTH, VA. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensee 22. Neme end Address of Facility WM. REESE & SONS MORTUARY, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, Applications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, Applications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Final disaese or condition rasulting in daath) /Medical OSMOLAT Examiner Examiner natremia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest buriel-tran and physician achydiation Physician/Medical the (or as e consequence of): P.O. Pert ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown 2 signed b Division of Vital Records. Aq 24b. Were autopsy findings available prior to 24e. Wes en autopsy Completed completion of cause of death? 1 ☐ Yes 2 No 2 No 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) 1 ☐ Yes PT No 27. Manner of Deeth Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Department 2 ER/Outpetient Certification: To 3□ DOA this funeral 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Naturel or Attending 5 Pending aftar death. Director: Aft 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 Sulcide 281. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide • Hospital 24 hours a • Funeral 12 Cartifying Phyalcian: To the best of my knowledge, death occurred et the time, deta and place, end due to the ceuse(s) end menner es stated. 2 Madical Examiner: On the bash of examination and/or investigetion, in my opinion, deeth occurred et the time, date and place, and due to the ceuse(s) and manifed stated. 29a. Certifier Medical (Check only one)

29c, License number

141 of death (Item 23e) (Type, Print) 29d. Date signed (Month, Day, Year)

State Registrar

29b. Signature

Ce 4

30. Name and address of person with

31. Date filed (Month, Dey, Year)

Tank

**DHMH 16 Rev 6/95** 

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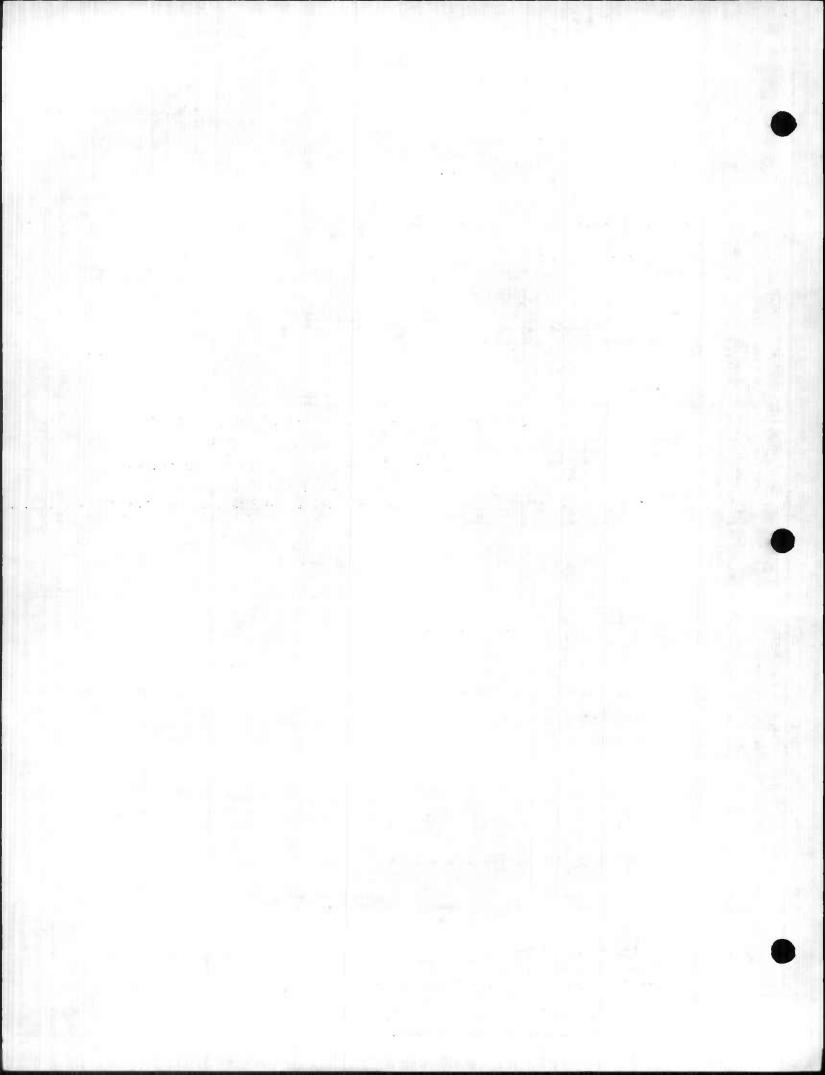
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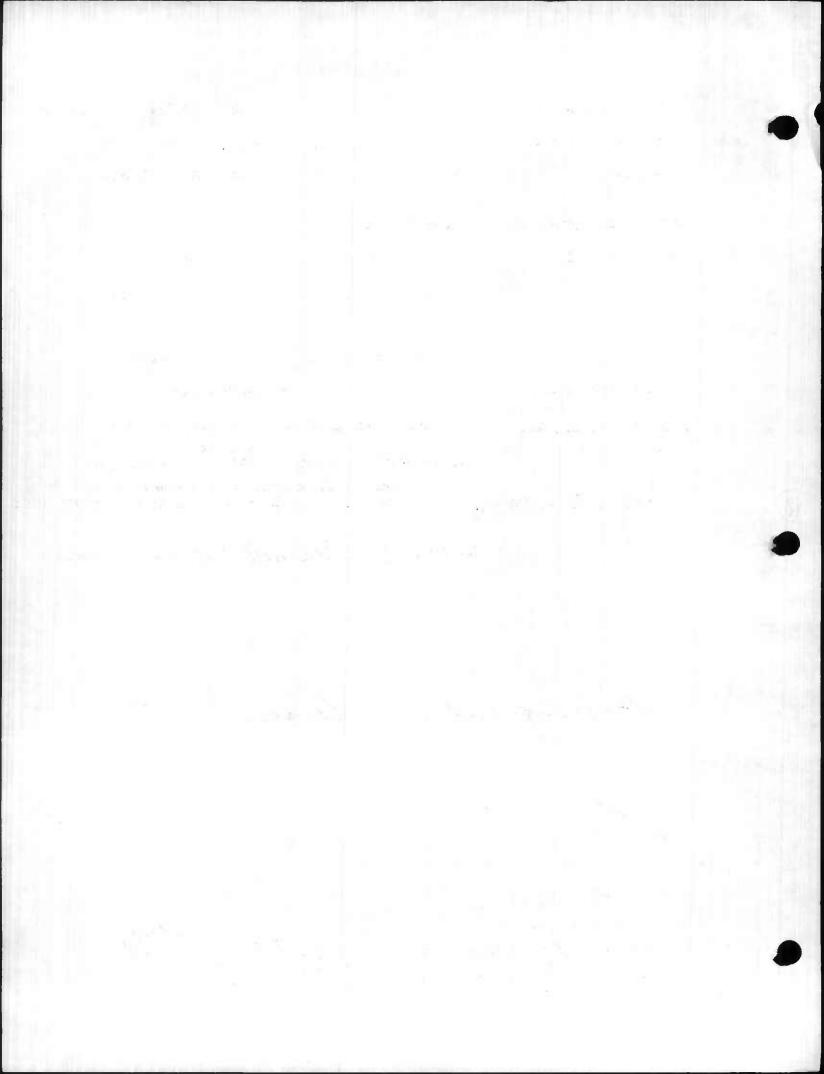
State of Maryland / Department of Health and Mental Hygiene

			Ce	rtificat	e of D	eath		Reg. No.	5 64	204	
	1. Decedent's Nama (First, Middle, Las	st)					2. Data of De Month	ath		Tima of Death	
Physician /Medical	Lucille Mary Bizo	ot						18, 1999	Year 3:	10pm	
Examiner	4a Facility Name (If not institution, give	e street and number)			4b.	City, Town, o	r Location of Deat	_			
	Bedford Court Nu	rsing Home			Si	lver S	pring	Montg	gomery		
Funeral	5. Social Security Number 6. S	DM 20E	s. last birthday)  Yrs.	Months		Munder 24 Hi Hours Mi	n. (Month, De	th ly. Year)	9. Birthplace (Country)	(State or Foreign	
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or 28a-1 e be notified Director	Maryland Montgomes	ry per.	hesda	10f. Zip	Code			10g. Citizen of V	What Country?	21	
natural', or itema 23a or 28a-f ehow deal Examiner must be notified at sted by Funeral Director	7616 Carteret Roa	ad		208				USA	,		
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by Br.	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forcas? 1 ☐ Yes 2♣ No If Yes, Giva Yaar or Datas:		1 Yes, spec			erto Hican, atc.)		ck, Whita, atc. White		
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9 0	Franz Joseph Pardu	ıhn				Mary A	gnes Stu	pp			
reumetic ev	19a, Informant's Name/Relationship (1	Type, Print)	19b. Maili	ing Addrass	(Street an	d Number or I	Rural Route Numb	er, City or Town,	State, Zip Code	9)	
4	Mary Frances Frank	klin/Daughter	7616	Cart	eret	Road,	Bethesda	, MD 208	317		
eny Injury or other treumatic event, me the pates.  To Be Comp	20a. Mathod of Disposition 1 □ Burial 2 □ Cramation 3 □ 4 □ Donation 5 □ Other (Specify	Hemovai from Stata	Place of Dispo cemetery, create te of H				July 21		City or Town, S		
는 는	21. Signatura of Funeral Service Licen					ot Facility	1999	Silver S	Spring,	MD	
eny l	22. Nama and Addrass of Facility  Francis J. Collins Funeral Home, In  500 University Blvd.W., Silver Sprin  23a. Part1. Enter Ma disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart tailura. List only one cause on each line.										
cian	23a. Part1. Enter Ma disease, or comp shock, or haart tailura. List only	plications that caused the de one cause on eech line.	ath. Do not en	ter the mod	le of dying,	such as cardi	ac or raspiratory a	rrest,	Inter	roximata val Between et and Death	
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	resulting in death)		(or as a conse						1		
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Physician/A									Ţ.		
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orrector, page 2	25. Was casa rafarred to medical axaminer?	Hospital:					eeth (Check only	one)			
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Cat	2 Accident invastigation 3 Suicide 6 Could not be			М		s 2 No					
Certification:	4 Homicida determined	28a. Place of Injury - At building, atc. (Spec	homa, tarm, st cify)	reet, tactory	y, office		28t. Location ( City or To	Street and Numb wn, State)	per or Rural Rou	ite Number,	
Completely filled in by the funeral Medical Certification: 1		ysician: To the best of my kr liner: On the basis of axamir and manner stated.								cause(s)	
Me Me	29b. Signature and title of certifier			290	c. License	number		29d. Data signe	d (Month, Day,	Year)	
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	20 Nome and address of any	nompleted source of death to	nm 02-1 /*		18726			July 19,	1999		
	30. Nama and addrass of person who				Dr C	lnor M	D 20822				
0.	Arthur Schoengold	MD 18111 Pr		тттр	טויין ע	They, M	m 20032				
State Registrar	1111 9 1 100	7.	4.	ho	alls)	/					



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ı	Physic		1. Decedent's Nama (First, Middle, Last) William Fred Boxall					Day Yaar	3. Tima of Death
8	/Medid Examir		4a. Facility Name (If not institution, give street as	nd numbar)		4b. City, Town, or Lo	- т	, 1999 4c. County of Deeth	12:17pm
	Funerai Director	lei	Holy Cross Hospital  5. Social Sacurity Number  577-26-1423  6. Sex	7. Age (In yrs. last birth			8. Date of Birth (Month, Day, Yea	Montgomery	plece (State or Foreign
Т	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
	Maryti ed s	Pot	Maryland Montgomery						1 ☐ Yes 2 🛣 No
	r 28a	Director	10e. Street and Number	Silver S	10f. Zip Code		10g.	Citizen of What Cou	ntry?
	th wit	_	908 Laredo Road		20901		USA	A	
0000	n 72 hours efter death with the Maryland "netural", or items 23a or 28a-f show organ Examiner must be notified at	by Funeral	1 Nevar Married 2 X Marriad 1 If Ye	s Decedent Ever in U,S. ned Forces?  Ves 2 \( \sum \) No es, Give \( 1941-45 \) Ir or Dates: \( 1941-45 \)	13. Was Decedent of lif Yes, specify Cub  1 ☐ Yes 2X No		ecify Yes or No- Rican, atc.)	14. Rece - Ameri Black, White, Specify: Whi	etc.
21215-0020	d within giene. r than T	Completed	15. Decedent's Education (Specify only highest grade compl Elementary/Secondary (0-12) Coli	leted) lege (1-4or 5+)	Decadent's Usual Occu Give kind of work done life. DO NOT use retire	pation during most of worki d)	ing	. Kind of Business/In	dustry
	be filed tal Hygi d other	Be C	17. Father's Neme (First, Middle, Last)			18. Mother's Name	(First, Middle, Maio		
Maryland		10	James Albert Boxall				e Dilleha		
Mar	d 2 should th and Mer 7 Is marke traumatic		19e. informent's Name/Relationship (Type, Prin		Mailing Address (Stree				Code)
altimore, I	Heall Heall tem 2		Annie A. Boxall / WIFF  20a. Method of Disposition  1  Burial 2 Cremation 3 Removal  4 Donation 5 Other (Specify)	from State 20b. Place of cem etery	B Laredo Ro Disposition (Name of r, crematory or other pla eran's Ceme	100)	July 26	Location - City or Te	
Balti	permit. Peges Department of Important; If is any injury or once.		Signature of Funerel Service Licensee  23a. Pert Enter the disease, or complications shock by heart failure. List only one causi	0	Francis J 500 Unive	ess of Facility Collins rsity Blvd	Funeral H	lver Sprin	
	Physician /Medical Examiner	ner		Due to (or as a co	of Cole			10	Interval Between Onset and Deeth
68760,	ficate be executed physician and is the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last	Due to (or as a co					
			d.						
Вох	atte	cian							
, P.O.	that the led by th deteche	y Physician/M	Part II. Other algorificant conditions contributing  Output  Description  Part II. Other algorificant conditions contributing				23b. Did tobed		o the causa of death? bably 4 🗆 Unknown
Vital Records	ew requii is been s 2 should	Completed by					24a. Was an au performad	? av	fere eutopsy findings rallabla prior to empletion of cause death?
al H	T ate						1□ Yes	2 10 No 1	☐ Yes 2☐ No
Zit.	Physician: The this certificate ral director, page	o Be	25. Was case referred to medical examiner?  Hospital:	_/	_   Ot	26. Place of Death			
ion of	After fune	<del> </del>	27. Manne of Death 1 Natural 5 Pending 2 Accident investigation	Date of Injury 28b. TI	me of 28c. Inju	4   Nursing Ho	me 5 ☐ Residence 28d. Describe how in	e 6 □Other (Special of the following occurred o	(y)
Division	i Dift o	Certification:	4 Homicide	Place of Injury - At home, fan building, etc. (Specify)	m, street, factory, office		28f. Location (Street City or Town, St	t and Number or Run tate)	al Route Number,
	24 hours of Funeral letely filled	edical	(Check only 2 Medical Examinar: On	To the best of my knowledge, the besis of examinetion end. I manner stated.	death occurred et the ti or investigation, in my	me, date and place, a opinion, deeth occurre	and due to the cause ed at the time, date	e(s) and manner as a and place, and due t	stated. o the cause(s)
	To the within 2 To the complex	Me	29b. Signature and title of certifier	A Diato.	29c. Licen	se number	29d.	Date signed (Month.	Day, Year)
	10		Mun Tol	eubu - m	100	6674	. 7	12/199	
	10		30. Neme and address of person who completed MYRON L LE	d cause of deeth (Item 23a) (7	ype, Print) 230	I Stone	FIELD!	20"	
	Sta Registr		31. Date filed (Month, Day, Year)  JUL 23 1999	32. Registrar's Signature	1		7.10		



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

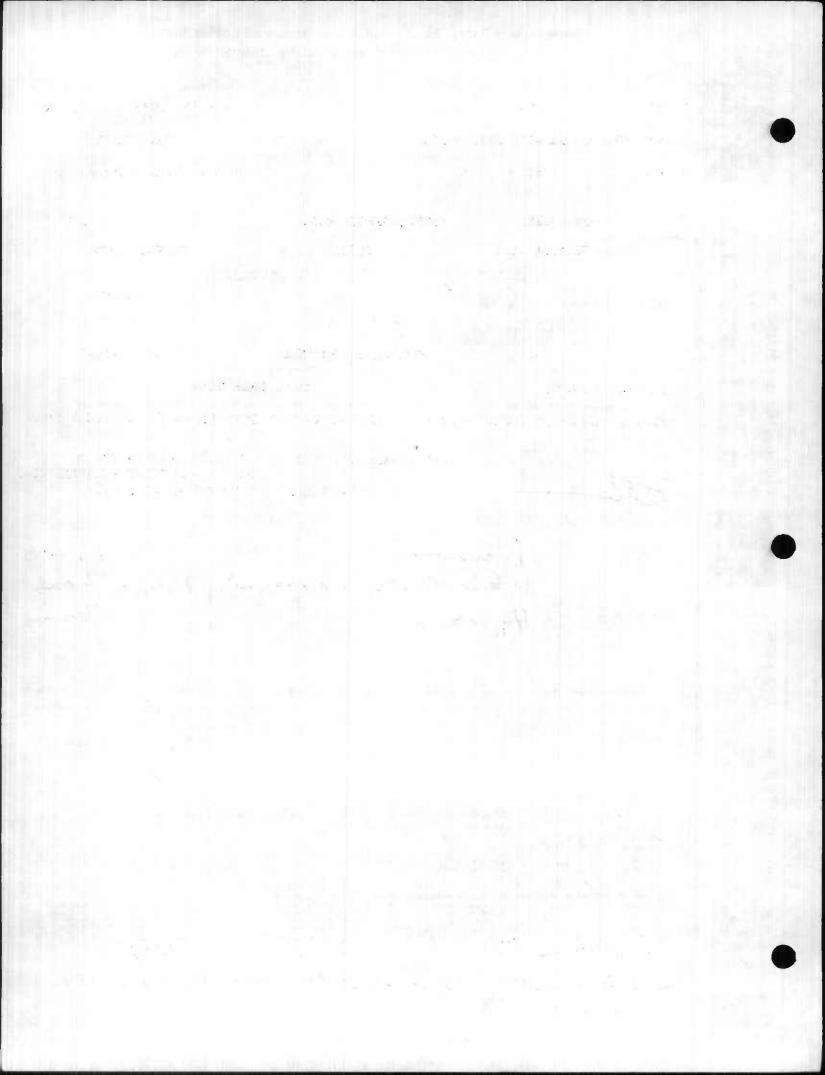
					Olale of I	viaiyiai		-	cate of		i Wientan i	Reg.		2	1286
	Physici	ion	1. Decedent's Neme (First, M	iddle, Li	ast)						2. Dete of E		Dey	Year	3. Time of Death
	/Medi			GEOR	GE EDWAI	RD BI	ROWN	, JR			JUL		19		6:45 PM
*	Examir	ner	4a. Facility Nama (If not Institu	itlon, gh	va street and numb	er)				4b. City, Town,	or Location of Dea	ath	4c. County	of Death	
L			NATIONAL NA	-					14. 15. 436	BETH				ONTGO	
	Funeral Director		5. Social Security Number 567–05–6369		Sax 7. 12⊠M 2□F	Aga (In yrs. 79			Undar 1 Yaar nths Days		in. 8. Dete of B (Month, L MARCH	Birth Day, Ye 6, I	920	9. Birthpi Count CAL I	aca (Stete or Foreign FORNIA
	and **		Usuei Residence of Decedant 10a, Stete 10b, Cou			10c. Ci	ty, Towr	or Locatio	n					10	d. Inside City Limits
	Se-f eho	ector		BERN	NADINO					BERNAD	INO				1⊠Yas 2□No
	h with th	al Dir	10e. Street and Number 873 BERNARD	WAY				10	of, Zip Code	9:	2404	10g.		What Count	y?
0	filed within 72 hours after death with the Meryland thygiene. ther than "natural", or ferma 23a or 28a-f show int, the Medical Exertive must be notified at	Funeral Director	11. Marital Status  1 □ Nevar Married 2 ☒ N	ferried	12. Was Decede Armed Force 1 12 Yes 2	s?	I,S.				(Specify Yes or Nerto Rican, etc.)	No-		e - Amarica ck, White, e	
21215-0020	72 hours af	by	3 ☐ Widowed 4 ☐ Divor		1 Tyes 2 ( If Yes, Give Yeer or Dete	s: WW	II	101	es 21 No	Specify:			Specify	WHI'	ΓE
5-0	72 hc	eted	15. Dece (Specify only hig	dent's E	ducation ade completed)		16a.	Decedent's	Usuei Occu	pation during most of i	vorkina	16b.	Kind of B	usiness/Indi	ustry
121	nen .	Completed	Elamentery/Secondery (0-1		Collega (1-4d	or 5+)		NGRES		nd)	· · · · · · · · · · · · · · · · · · ·			OUSE	
	filed with Hygiene. ther there		17. Father's Neme (First, Midd	lia I set	5 +		- 00	MGKE	OSPIAIN	18 Mother's N	lema (First, Middi			NTATI	VES
Maryland	should be filed withing Mental Hygiene. marked other than imatic event, the Mental Men	o Be			RD BROWN						RD KILGO		on Suman	ra/	
ary	2 should and Men is marke	To	19e. Informent's Neme/Relati	onship (	(Type, Print)		19b	. Meiling Ac	Idress (Stree		Rural Route Num		v or Town.	Stete. Zio	Code)
			MARTA MACIAS E	ROW	N - WIFE			_	NARD W.		BERNADII			92404	,
altimore,	of He frem		20a. Mathod of Disposition		70	20b. i	Plece of	Disposition	(Name of y or other pia	ice)	Date	20c.	Location -	City or Tov	vn, State
Ē	Pag ment: M uny o		1 ☐ Burial 2 ☑ Cramatic 4 ☐ Donetion 5 ☐ Other			la l			EMATOR		7/22/99	FAI	LLS C	HURCH	, VIRGINI
Balt	permit. Pages 1 and 2 Department of Health s important: If Item 27 is any injury or other tra pncs.		21. Signeture of Funerel Serv	Ce Lice	nsee	bele	er.			ess of Fecility . E. N.W.	JOSEPH GA				20016
4	-		23a. Pert1. Enter the disease shock, or heert feilure. I	or com	plications thet caus	sed the dee	th. Dor	1							Approximata Interval Between
3	Physician		shock, or need fedure.	ist <i>Only</i>	One ceuse on eec	i iine.									Onsat and Deeth
1	/Medical Examiner		tmmediete Cause (Finel disaase or condition		ASY	TOLE									
п	LAditime	<u></u>	resulting in death)		0.		or es e c	consequenc	e of):					1	
	bet nsit	nine			SEP:										
90,	ificete be executed g physician and es the burlei-transit	al Examiner	Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events	J	MUL			SYSTE	e of): M FAIL	URE				 	
68760,	physic the t	edical	thet initieted events resulting in daath) Last	1		Dua to (d	or as a c	onsequanc	e of):						
		95		L	d. PROS	STHET	C V	ALVE	ENDOCA	RDITIS	and RHEU	MAT]	C VA	LVULA	R DISEASE
Box	death cert e attendin ed for use	Physician/N	Pert II. Other significant cond	littana	antibuting to doub	but not road	Min or In	the constant	des serves et	una la Dant I	nah Di	d toboo		ndelbuda da	the cause of death
0	thet the de ed by the a detached	hys	reitii. Otter eignineam conc	ntione c	contributing to death	Dutiloties	uning ii	ure under	And cause di	AGURIL GILL					ably 4 Unknow
S, P	es the igned be del	by F									_				
Records,	been s should	Completed	***************************************								24e. We per	es an au rformed		con	re autopsy findings itable prior to apletion of cause eath?
R	The lew ate has page 2	omo									tλC	Yes	2 🗆 No		Yes 210 No
Vital		Be C	25. Wes case referred to med	ical						26. Plece of I	eeth (Check only	one)			
of V	D 50	To	exeminer? 1 ☐ Yes 2]∑ No		Hospital: 12 Inpe	atient 2	ER/Ou	tpetient 3	DOA O	her: 4 Nursing	Home 5□Re	aidence	8 Oth	ar (Specify,	)
ם	of the control		27. Menner of Death 1 Noturel 5 □ Per	ding	28a. Dete of I (Month, i	njury Day Year)		ime of njury	28c. Inju Wo		28d. Dascribe	e how in	njury occur	red	
Sio	Attending or death. ector: After by the fune	cat	2 Accident Inve	stigetio		Colonia (Ass.)		N		Yes 2□No	206 Lacation	/C+===	a m of Ali on A	D/	Do do Manhar
Division		Certification:		mined	288. Piece of	atc. (Speci	ome, te	rm, street, 1	ectory, office		City or T			er or Hurai	Routa Number,
	spital cours seral filled		29e. Cartifier No Certif	vina Ph	nysician: To the be	st of my kno	wledge	daeth occi	urred et the ti	me, dete end ple	ce, end due to th	e ceuse	(s) end ma	nner as sta	ited.
	To the Hospital or within 24 hours after To the Funeral Dir completely filled In	edicai	(Check only one) 2 Medic	at Exar	niner: On the basis end menner	of examina	tion and	d/or Investig	etion, In my	opinion, deeth o	curred at tha time	e, dete	end plece,	and due to	the cause(s)
	To the To the Comp	Σ	29b. Signeture end titla of page	fier					29c. Licen	sa number		29d. l	Data signe	d (Month, D	ay, Year)
	15					- n	D		0101	-56879	(VA)	7	/16/	99	
	17		30. Neme and eddress of pers				n 23a) (	Type, Print)			AL NAVAL		ICAL	CENT	ER
			E. A. ELSTER  31. Dete filed (Month, Dey, Ye				htura	_		BETHES	DA MD 20	889-	-5600		
	Sta Registr			19		strer's Signo		G. ,	Space	2					

THE RESERVE OF THE PROPERTY OF

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Discontinue	1. Decedent's Nemo	e (First, Middla, La	ist)		Oerun	icate of	Death	2. Date of Dea	ith Day	Year 3.	Time of Death
Physician /Medical	NATHAN		BURNS					JULY 1	8, 1999	1:	10 AM
Examiner	4a Facility Neme (// HEBREW HO)		e street and number		J		4b. City, Town, or LOCKVILLE	Location of Deeth	4c. County MONTG		
Funeral Director	5. Social Security N 579-10-16	umber 6. S		ge (In yrs. las	st birthday)   If	Under 1 Year onths Days	If Under 24 Hra Hours Min	8. Date of Birth			(Stata or Foraign
1	Usual Residence of 10a, State	Decedent 10b. County		10c. City,	Town or Location	on				10d. in	side City Limits
28a-f ehow notified at	MD	MONTGON	MERY	ROO	CKVILLE					1	XYes 2□ No
0 2 0	10e. Street end Nur 612	nber 1 MONTRO	SE ROAD			of. Zip Code 20852			10g. Citizen of V UNITED		
f, or its	11. Maritel Status 1 ☐ Never Marri 3 ☐ Widowed	ed 2 Married	12. Was Deceden Armed Forces 1 XYes 2 til Yes, Give Year or Dates	? INO WW	II _	Decedent of H s, specify Cub Yes 2 □XNo	dispenic Origin? (Sen, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		e - American Inc. k, White, etc.	dien,
lete office	(Spec	15. Decedent's E ify only highast gra ndary (0-12)	ada complated) College (1-4or		lifa. DO l	of work dona NOT usa retire	during most of we d)	nrking	16b. Kind of Bu		
d other event, p	17. Father'a Name (	First, Middle, Last	4+		MECHANI	CAL EN		me (First, Middle,			
marked o	SCHMUEL	MA NAKAM					RAHEL G	REENBERG			
9 5 3	19a. informant'a Na BERNICE.		Type, Print) POWER OF	ATTORN				ROAD #30			
y or	20a. Method of Disp	position	Removal from State	20b. Pla	ce of Disposition natary, crameto	n (Name of ry or other pla	ce)	Date 7/20/99	20c. Location -		State
Department of Important: If any Injury or once.	21. Signature of Fu			11011	22. Na	me and Addre	ess of Fecility DA	NZANSKY- E ROCKVI	GOLDBER	G MEMOR	
ling physician and e as the burial-transit	Sequentially list con if any, leading to im cause. Enter Unde Cause (Disease or that initiated events resulting in death) L	nditions, mediate rlying Injury .ast	Hype	Due to (or a	as a consequent	ca of):	ioraze	ulay a	lisean	e 7e	ans
d by the ettending etached for use a Physician/Me	Pert II. Other slanifi	cant conditions	contributing to death	but not result	ing in the under	tvina cause ai	ven in Part i	23b Did t	obacco usa co	ntribute to the	cause of death?
een signed by the ettendin hould be detached for use eted by Physician/N			ormouning to down	out not rosult		lying oddoo gi		10	/		4 □ Unknowi
should should									an eutopsy med?	available	utopsy findings e prior to tion of cause 1?
director, page 2								101	ea 2DNo	1 ☐ Yes	2 No
rector rector	25. Was case referrence examiner?		Hospital:			- Ott	non /	eth (Check only o			
五一 一	1 ☐ Yes 2 ☐ 27. Menner of Deetl	n	28a. Dete of In	ient 2 El	8b. Time of	28c. Inju	4 UP Nursing	Home 5 Resid	ow Injury occur		
within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Medical Certification:	1 Neturel 2 Accident 3 Suicide 4 Homicide	5 Pending Investigatio 6 Could not be determined	e 28e. Place of II		Injury Injury Injury	M 1	Yes 2 No	28f. Location (S City or Tow	Street and Numb m, State)	er or Rural Rou	sta Number,
within 24 hours to the Funeral I completely filled	29a. Certifier (Check only one)		nysician: To the bes niner: On the basis end manner s	of examinatio							
Tothe	29b. Signature and	title of certifier	MD			29c. Licens	3450	ekv.)le	29d. Date signe	d (Month, Day,	Year)



that the death certificate be executed Division of Vital Records, P.O. Box 68760, or Attending

the Meryland

Baltimore, Maryland 21215-0020

r 28a-f show

physician end the burial-transit 98 for use signed l page 2 s hes certificate director. this funeral After

death. efter deatl 24 hours e

Certification:

28f. Location (Street and Number or Rural Route Number, City or Town, Steta)

29a. Certifier 1 📃 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end menner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29d. Data signed (Month, Dey, Year) 29b. Sign and title of certifier 29c. License number SNO

01523L

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARL MARGOLIS, MO. (DMB)

11125 ROCKVILLE PIKE, ROCKVILLE, IND 20852

State Registrar

Medical

pletely

To the I

C

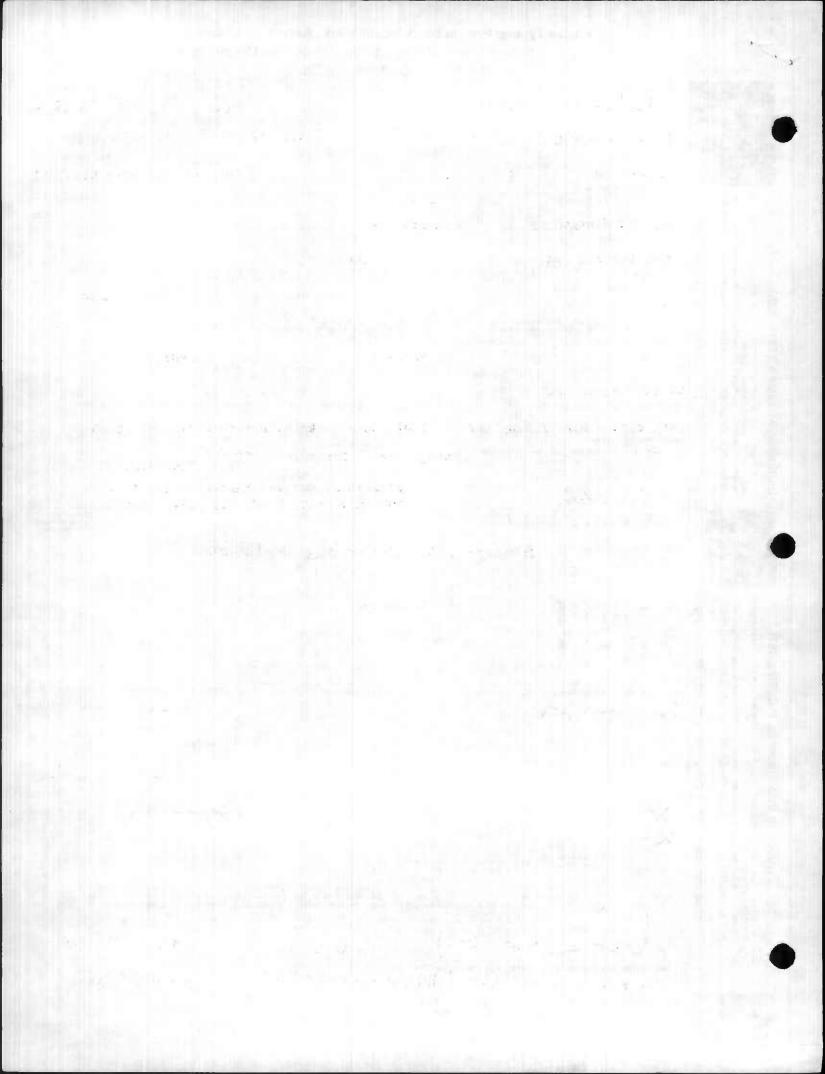
31. Date filed (Month, Dey, Year)

23

32. Registrar's Signature

souls

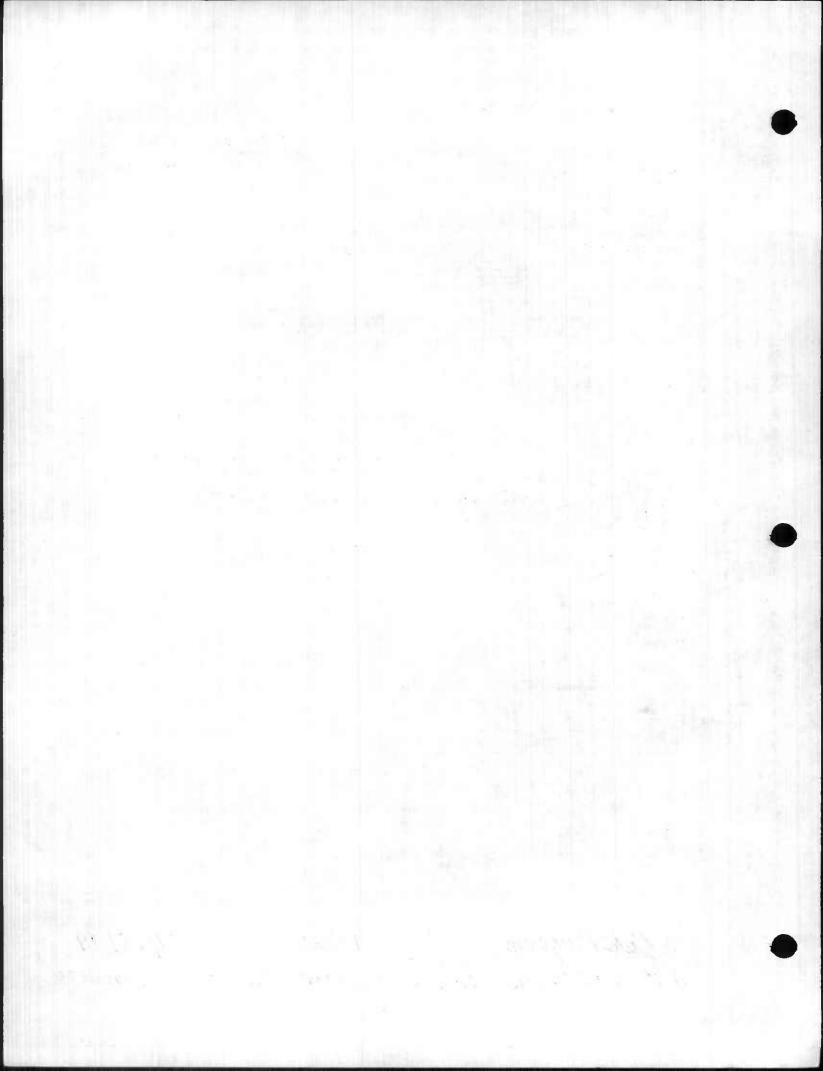
Hospital



State of Maryland / Department of Health and Mental Hygiene

Completed by Funeral Director	Maryland Mo  10a. Street and Number  5911 Ryland  11. Meritel Stetus  1 Never Merried 2  3 Widowed 4 DO  (Specify only Elementery/Secondary 12	HOSPIT  6. S  1  dent  County  ntgome  Drive  Merried ivorced	e street and number a1 ex 7. A	ge (In yrs. Ias 35 10c. City, Bet]	Yrs. Town or Loc hesda	10f. Zip Code	ys Hours Min	Location of Deat	Montg	of Death Omery  9. Birthplaca (St. Country) Maryland  10d. Insk	: 28 AM  ate or Foreign  de City Limits		
miner frail	4e Facility Name (If not In Holy Cross  5. Social Security Number  578-82-4217  Usual Residence of Decer  10a. Stete 10b.  Maryland Mo  10a. Street and Number  5911 Ryland  11. Meritel Stetus  1 Never Merried 2  3 Widowed 4 SD  (Specify only Elementery/Secondery 12	HOSPIT  6. S  1  dent  County  ntgome  Drive  Merried ivorced	e street and number  2.a1  ex 7. A  M 2 F  12. Wes Deceden Armed Forces 1  Yes 2 M If Yes, Give	ge (In yrs. Ias 35 10c. City, Bet]	Yrs. Town or Loc hesda	Months Day	Silver Sp ar If Under 24 Hrs ys Hours Min	ring  8. Dete of Bir (Month, De	Montg	of Death Omery  9. Birthplaca (St. Country) Maryland  10d. Insk	ate or Foreign		
ral	Holy Cross 5. Social Security Number 578-82-4217 Usual Residence of Decer 10a. Stete 10b. Maryland Mo 10a. Street and Number 5911 Ryland 11. Meritel Stetus 1 Never Merried 2 3 Widowed 4 ED (Specify only Elementery/Secondery	Hospit 6.S 1 dent County ntgome Drive  Merried ivorced	2. Wes Deceden Armed Forces 1 1 Yes 2 1 1 Yes, Give	ge (In yrs. Ias 35 10c. City, Bet]	Yrs. Town or Loc hesda	Months Day	Silver Sp ar If Under 24 Hrs ys Hours Min	ering 8. Dete of Bir	Montg	omery  9. Birthplaca (St County)  Mary Land	1		
tor	5. Social Security Number 578-82-4217 Usual Residence of Deced 10a. Stete 10b. Maryland Mo 10a. Street and Number 5911 Ryland 11. Meritel Stetus 1 Never Merried 2 3 Widowed 4 DO (Specify only Elementery/Secondery 12	dent County ntgome Drive  Merried ivorced	2 TY  12. Wes Deceden Armed Forces 1 1 Yes 2 12 14 Yes, Give	35 10c. City, Bet1	Yrs. Town or Loc hesda	Months Day	ar If Under 24 Hrs ys Hours Min	8. Dete of Bir	th	9. Birthplaca (St Country) Mary Land	1		
tor	Usual Residence of Decer 10a. Stete 10b.  Maryland Mo  10a. Street and Number 5911 Ryland  11. Meritel Stetus 1 Never Merried 2 3 Widowed 4 SD  (Specify only Elementery/Secondery 12	dent County ntgome Drive  Merried ivorced	2 M 2 F  12. Wes Deceden Armed Forces 1 Yes 2 K	35 10c. City, Bet1	Yrs. Town or Loc hesda	Months Day	ys Hours Min	(Month, De	4, 1964	Mary Land	1		
_	10a. Stete 10b. Maryland Mo  10a. Street and Number  5911 Ryland  11. Meritel Stetus  1 Never Merried 2  3 Widowed 4 DO  (Specify only Elementery/Secondary 12	County ntgome Drive  Merried ivorced	12. Wes Deceden Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give	Betl	hesda	10f. Zip Code	9				le City Limits		
Completed by Funeral Director	10a. Street and Number 5911 Ryland 11. Meritel Stetus 1 Never Merried 2 3 Widowed 4 D (Specify only Elementery/Secondary	Drive  Merried ivorced ecedent's Ec	12. Wes Deceden Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give	t Ever in U,S.			9			10			
Completed by Funeral Direct	5911 Ryland  11. Meritel Stetus  1 Never Merried 2 3 Widowed 4 SD  (Specify only Elementery/Secondary	☐ Merried ivorced ecedent's Ed	Armed Forces 1 Yes 2  If Yes, Give	7			9				Yes 2X No		
Completed by Funeral Di	5911 Ryland  11. Meritel Stetus  1 Never Merried 2 3 Widowed 4 SD  (Specify only Elementery/Secondary	☐ Merried ivorced	Armed Forces 1 Yes 2  If Yes, Give	7					10g. Citizen of W	That Country?			
Completed by	11. Meritel Stetus  1 Never Merried 2  3 Widowed 4 SD  (Specify only Elementery/Secondary	☐ Merried ivorced	Armed Forces 1 Yes 2  If Yes, Give	7		2081				d States			
Completed by	1 Never Merried 2 3 Widowed 4 St D (Specify only Elementery/Secondary	ivorced ecedent's Ed	Armed Forces 1 Yes 2  If Yes, Give	7	13 V			Specify Yes or No	- 14 Race	- American India	n.		
Completed by	3 Widowed 4 \$\text{\text{\$M\$}} D \$  (Specify only Elementery/Secondary 12	ivorced ecedent's Ed	If Yes, Give		1f	Yes, specify C	of Hispanic Origin? (S uban, Mexican, Puer	to Rican, etc.)	Bleck	k, White, etc.			
	15. D (Specify only Elementery/Secondery 12	ecedent's Ed			1	☐ Yes 2⊠N	lo Specify:		Specify:	White			
	(Specify only Elementery/Secondary 12	highest gra	lucation		16a Deced	ent's Usual Oc	cupation		16b. Kind of Bu	siness/Industry			
1	12	1	de completed)		(Give I	kind of work do	cupation ne during most of wo ired)	rking					
5		(0-12)	College (1-4or	5+)		od Work			Wood W	orking			
	17. Father's Neme (First, I	Middle, Last)			.,,,,,			me (First, Middle	Maiden Surname				
5	Thomas Baldw							ne Kean					
-	19e. Informant's Neme/Re		Time Print		10h 84-20	n Address (O:				State Tie Code:			
- 1	Kevin J. Bal						Street, S						
			22 001101	20h Di-	on of Dispos	nition (Name of		Date:		City or Town, Stel			
1	20e. Method of Disposition 1 ☐ Burlel 2 ☑ Cren		Removel from Stete	Cen	netery, crem	natory or other	place) July 19						
	4 □ Donation 5 □ O		1.1		tgomen	ry Crem	atorium,	Inc.	Bethesda				
20 21	22. Name and Address of Facility Robert A. Pumphrey Funeral Hot Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501  23a Fart I First of deese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate Intervel Between												
	23a. Part 1 Har vio dine	ese, or comp e. List only								Approx Interve Onset	imete I Between and Death		
	Immediate Causa (Final disease or condition		Metas	tatic	Lung (	Carcino	ma			8 m	onths		
	resulting in deeth)			Due to (or a	as a consequ	uence of):				1			
LAM	Sequentielly list condition if any, leeding to immedie cause. Enter Underlying Cause (Disease or injury	s, te	b	Due to (or a	ns e consequ	uence of):							
0	Cause (Disease or injury that initiated events resulting in deeth) Last	1	С	Due to (or a	is a consequ	uence of):					150		
Physician/M			d										
200	Part II. Other algnificant o	onditions co	ontributing to death	but not result	ing in the un	derlying cause	given in Part I.	23b. Did	tobacco usa con	tribute to the ca	use of death		
29 5119								10	Yaa 2□ No	3 Probably	4K Unknow		
Completed								24a. Wes	an autopsy ormed?	24b. Were auto available p completion of death?	rior to		
E								1□	Yes 2⊠No	1 ☐ Yes	2 No		
	25. Was case referred to r	medical					26 Place of De	eth (Check only					
To Be	exeminer?		Hospitel:	ient all m	R/Outpatient	3 DOA	Other		dence 6 Othe	ar (Snecihi)			
Certification: T	27. Menner of Death 1 X Netural 5	Pending Investigation	28a. Dete of Inj (Month, D.	ury 2	28b. Time of Injury	28c. lr		1	how injury occurr				
D IIII C	2 Accident 3 Suicide 6 4 Homicide	Could not be determined	28e. Pleca of Ir	njury - At hom tc. (Specify)	ne, ferm, stre				Street and Number wn, State)	er or Rural Route	Number,		
				of exeminetio			time, date and place y opinion, death occ				ise(s)		
	29b. Signeture and title of	pertifier	and meaner 3	10100.		29c. Lice	ense number	1	29d. Date signed	(Month, Day, Ye	ar)		
1	Misc	Dance	A AAAA										
	Many	nug	gumo			Vol	3308		01/1	0/1/			
3	30. Name and address of VICTOR M. H	PRIFE	completed cause of	death (Item 2 770 7	23a) (Type, F	Print)	3308 COMEN DU	. Roca	KVIUE,	ND 208	50		

DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene 99 24290

			Certificate of	Death	Re	ig. No.	64600
	Decedent's Name (First, Middle, Last)				2. Date of Deatl	1	3. Time of Deeth
Physician /Medical	LUCINE ROSE	EMARY I	BARTLEY		Month JULY		99 4:30 AM
Examiner	4a Facility Name (If not institution, give street and numb	er)		4b. City, Town, or Lo	cation of Death	4c. County of	
á III.	4021 72nd AVE.			LANDOVER	HILLS	PRINC	E GEORGES
Funeral Director	220-96-5932 1DM 20F	Age (In yrs. last birth	hday) If Under 1 Year Months Days		8. Date of Birth (Month, Day, NOV 9		Birthplace (State or Foreign Country) JAMAICA
Du .	Usual Residence of Decedant  10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
f aho	MD. PRINCE GEORGES	Too. Oxy, Town		TTTTC			1 Yes 2 No
the 1	10e. Street and Number		LANDOVER I	TITIO	10	g. Citizen of Who	at Country?
If the death with the Meryland I terms 23s or 28s-f show ither must be notified at Funeral Director	4021 72nd AVE.			784		U.S	
items 2	11. Marital Status 12. Was Dacede Armed Force		13. Was Decedent of I If Yes, specify Cub		acity Yas or No-	14. Race -	American Indian,
DY by	1 Nevar Married 2 Married 1 Yes, Give 2 If Yes, Give Yaar or Data	M No	1 ☐ Yes 2 No		rucan, etc./	Specify:	White, etc. BLACK
5-00.72 hours natural;	15. Decedent's Education	16a. (	Decedent's Usual Occu	pation	1	6b. Kind of Busin	
ind 21215-0 be tiled within 72 ho lal Hygiene. 4 other than "natur event, the Hodell Be Completed	(Specify only highest grade completed)  Etementary/Secondary (0-12) College (1-4)		(Give kind of work done life. DO NOT use retire	iduning most of work id)	ing		
d 21 tiled wit Hygiens ther the	12		NURSE	AID			TH CARE
	17. Fether's Neme (First, Middle, Last)	1.00		18. Mother's Name	e (First, Middle, N	feiden Sumame)	
Should nd Men marks Immeric		ENZIE			LANTINE	CRO	
E 01222	19e, Informant's Name/Retationship (Type, Print)		Meiling Address (Stree				ite, Zip Code)
E E OL	KEVIN SYDNEY BARTLEY/SON  20a. Method of Disposition		07 DRISCOLI Disposition (Name of	L DR., BOW		20720 20c. Location - Cit	hy or Town State
altimore, mit. Pages 1 ar partment of Hee portant: if Nem. Vinjury or othe	1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from Sta	cemetery	, crematory or other ple				
nit. Pa artme ortant injury	4 Donation 5 Other (Specify)	CEDA	R HILL CEM		/26/99	SUITLA	ND, MD.
D Sepa	21. Signature of Funeral Service Usensee	_ M00091	22. Nama and Addre		MES.P.A.	. RIVER	DALE, MD.20737
Physician	23a. Part1. Enter the disaasa, or complications that caus shock, or heart failure. List only one cause on each	sed the death. Do no h line.					Approximate Interval Between Onsat and Death
/Medical Examiner	Immediate Causa (Final disease or condition resulting in death)	TASTAT		AST (	and	35	IYR
9	6	Due to (or as a co	onsequence of):				6 mas
executed n and ial-transit	0	Due to (or as a co	onsequence of):				c mas
b8/b0, filicate be executed to physician and as the burial-transit Aedical Examir	Sequentially list conditions, If any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events						
E 0 8	resulting in death) Lasf	Due to (or as a co	onsequence of):				t 1
death cert death cert e ettendin sd for use							i
. 0 00	Part II. Other significant conditions contributing to death	n but not resulting in	the underlying cause gi	iven in Part I.	23b. Did to	bacco use contr	ibute to the cause of death?
					1 🗆 Ya	2 2 No 3	Probably 4 Unknown
MECOTGS, e law requires ti has been signe ge 2 should be e					24a. Was ar		24b. Ware autopsy findings available prior fo
					perform	IBU r	completion of cause of death?
The law ale has begge 2 s					1 ☐ Ye	s 20 No	1 ☐ Yes 2 ☐ No
VITAL MEC elcian: The law certificate has t lirector, page 2 s	25. Wes case referred to medicat			26. Place of Deat	h (Check only one	9)	
- S 00 0	axaminer? 1 ☐ Yes 2 No Hospital: 1 ☐ Inp.	atient 2 ER/Out	patient 3 DOA Ot	her: 4 Nursing Ho	me 5 Reside	nce 6 Other	(Specify)
iding Phy th. After this funerel d	27. Manner of Death 1 Neturel 5 Pending (Month,	njury 28b. Ti Dey Year) Inj	jury Wo	ry at ork? ] Yes 2 □ No	28d. Describe ho	w injury occurred	
DIVISION (  tal or Attending P  rs efter deeth.  al Director: Aftert led in by the funer.  Certification:	3 Suicide 6 Could not be determined 28e. Placa of	Injury - Af homa, fam etc. (Specify)	m, streef, factory, office		28f. Location (Str City or Town	reet and Number , Stete)	or Rural Route Number,
To the Hospital or Attending Ph within 24 hours efter deeth. To the Funeral Director: After thi completely filled in by the funeral Medical Certification:	29a. Cartifier (Check only 2 Medical Examiner: On the basis	s of examinetion end	death occurred at the ti	ime, date and place, opinion, deeth occur	and due to the ca	use(s) and mann ite and place, and	er as stated. d due to the cause(s)
thin 2 the land	one) and manner	STATEO.	29c. Licen	se number	20	d. Data sinned /	Month, Day, Year)
5	· Carof frud	ules	MD D3	7236	,	MLY 22	1999
4	30, Neme and address of person who completed cause of ARCYN HENDRICKS	of death (Item 23a) (T	Type, Print) 201 MG	DICAL PA	ex De.	SILVER	Spring M)
State Registrar	31. Date filed (Month, Day, Year) 32/Regi	istrar's Signature	knowle	/			1

DHMH 16 Rav 6/95

AREAN TO E. .. Land of the state 

Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** Douglas D. Bazata July 1999 15 12:50 A.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital If Under 1 Yeer

This Days Montgomery Bethesda If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 12 M 2 F Hours 579-10-0438 Yrs. 88 Feb. 17, 1911 Pennsylvania Director Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits na 23a or 28a-f shor must be notified at MD 1 X Yes 2 □ No Montgomery Chevy Chase Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2921 Terrace Drive "natural", or flame 23a 20815 U. S. A. 14. Race - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 72 hours after 1 Yes 2 No
If Yes, Give
Year or Dates: WW II 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) Assistant to 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 7 Hygiens. other then "n Elementary/Secondary (0-12) College (1-4or 5+) Department of Navy the Secretary of the Navy 18. Mother's Neme (First, Middle, Maiden Surname) parmit. Pages 1 and 2 should be file Department of Health and Merial Hy Important: if then 27 is marked ofth any fillury or other trearmatic event adds. 17. Father's Name (First, Middle, Last) 99 Charles Bazata Alma Eaglettinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2921 Terrace Drive Marie-Pierre Bazata Wife Chevy Chase, MD 20815 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 7/19/99 Falls Church, Virginia 4 □ Donation 5 □ Other (Specify) National Crematory 22. Name and Address of Facility Joseph Gawler's Sons 21. Signature of Funeral Service Licensee Themas E. Tionnbaker 5130 WI Ave. N. W. Washington, D.C. 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Cancer Examiner physician and a the burlai-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Physician/Medical Due to (or es e consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Onknown Heart Failure, Pneumonia ğ 24b. Were autopsy lindings aveilable prior to completion of cause of death? 24a. Wes en autopsy performed?

1 after Funeral

Completed 88 10 Certification: edical

To the Ho within 24 I To the Fu D

1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 VNo N Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 | Natural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, lectory, office building, etc. (Specify) 4 Homicide

Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated. (Check only one) 29b. Signeture and title of certifier 29c. License number

Amathan MD 53615

29d. Date signed (Month, Day, Year)

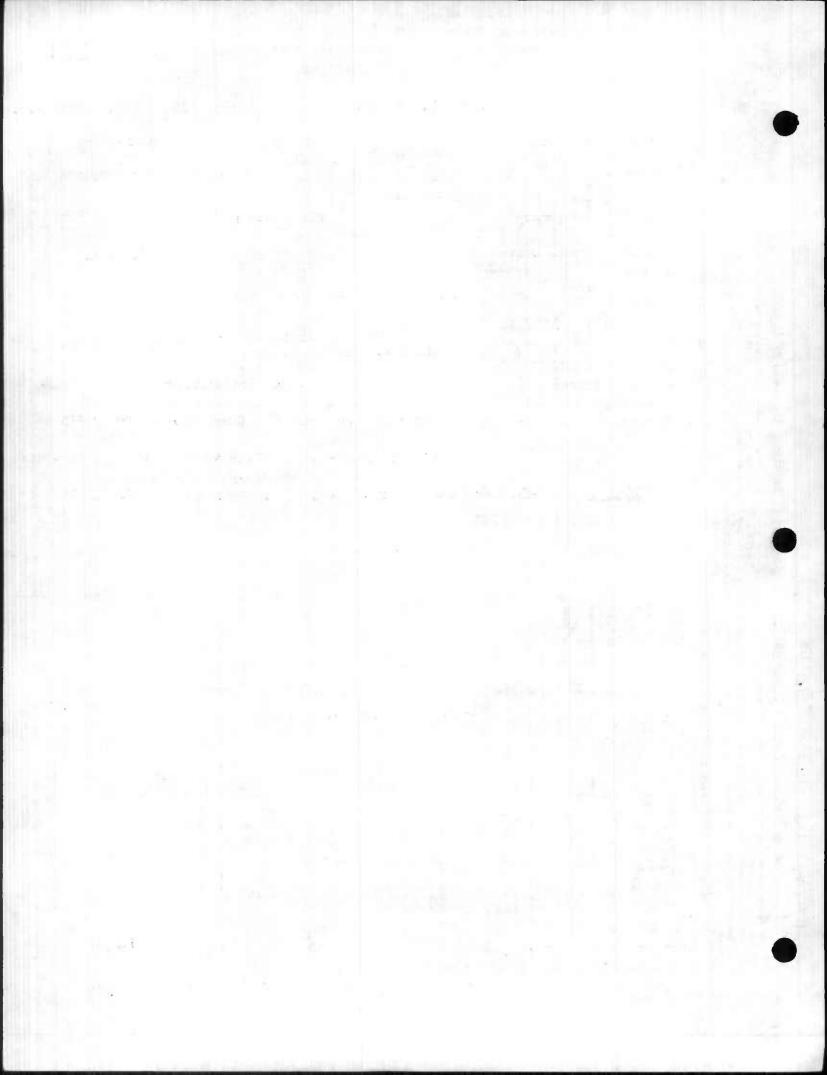
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Aruna S. Nathan, Congri Congressional Lane, Rockville MD 31. Date filed (Month, Day, Year)

State Registrar

JUL 1'9 1999

32. Registrer's Signature



A	END #2	3pa	rt1,
9			1. Dece
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0	r her	Fun	1 🗆
02	Phours after death with the Marylar trural", or itema 23a or 28a-f show as Examinar must be notified at	ed by Funeral Director	3%
5-0	natu	etec	
Baltimore, Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or herms 23a or 28a-f show ship injury or other traumatic avant, the Medical Examinar must be notified at once.	Be Complete	Elem
p	Hygin offied office of the rank, t	e C	17. Fatt
/lar	should be nd Menta marked imatic av	To B	Cha
lan	in and 2 should be Health and Ments fem 27 is marked other traumatic a		19e. In
2	X Health frem 27 other tr		A1b
Or	Pages 1 ent of H nt: If ite ry or ot		20a. Me
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9			23a. P
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10	g Phy ier this	T:U	27. Man
Sion	eath. or: Aft	satic	27. Man 1 (X) 2 (2) 3 (3) 4 (2)
Division of Vital Records, P.O. Box 68760,	or Attanding Physician: The law requires that the death certificata be axecutes after death.  Director: Atter this certificate has been signed by the attending physician and it in by the funeral director, page 2 should be detached for use as the bunta-trans	ertification: To Be Completed by Physician/Medical Examin	3 <u></u>
	1 4 0 5	0	

art1,7/20/99,BMW,M	ontg.Co.	Certifica			nemai m	Reg. No.	99	24292
1. Decedent's Neme (First, Middle, La	ist)				2. Dete of D		Vaca	3. Tima of Death
Ruth Frances Beal	1				July 1	Day 15,199	9 Year	1:40am
4a Facility Neme (If not institution, given	re street end number)			b. City, Town, or Lo	ocation of Dea	ith 4c. C	ounty of Dec	eth
Fairfield Nursing	Home		(	Crownsvil.	le	Ann	e Arui	ndel
,		Month	der 1 Yeer is Days	If Under 24 Hrs. Hours Min.	8. Dete of B	lav. Year)	9. Bi	rthplace (Stete or Foreign
Usual Residence of Decedant		31 Yrs.			Jan.	7, 191	8 Mas	sachusetts
10a. Stete 10b. County	10c. C	ity, Town or Location						10d. Inside City Limits
Maryland Anne Aru								1 ☐ Yes 2 ☐ No
10e. Street and Number		10f. Z	Zip Code			10g. Citize	n of What C	ountry?
416 Westbury Driv	е	211	40			USA		
11. Meritel Stetus	12. Wes Decedent Ever in t Armed Forces?	J,S. 13. Wes Dec	cedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or N	10-	. Rece - Am Bleck, Whi	erican Indien,
1 Never Married 2 Merried	1 Yes 2 No			Specify:	rucan, etc.)		pecify:Whi	
3₺ Widowed 4 Divorced	Yeer or Datas:	I Ca ras	25110	Specify.		5,	pecity:****	
15. Decedent's E (Specify only highest gro	ducation ade completed)	16a. Decedent's Us	work done	during most of work	ina	16b. Kind	of Business	/Industry
Elemantery/Secondery (0-12)	College (1-4or 5+)	life. DO NOT	use retired	9)				
12		Bookkeepe	r			AAUW		
17. Fathar's Neme (First, Middle, Last	)			18. Mother's Name	e (First, Middl	le, Maiden St	umama)	
Charles J. Lineha	n			Ruth Simo	on			
19e. Informant's Neme/Reletionship (	Type, Print)	19b. Meiling Addre	ss (Street	end Number or Run	al Route Num	ber, City or 1	Town, State,	Zip Code)
Albert P. Beall,	Jr./ Son	416 Westb	ury I	rive, Riv	va,MD 2	21140		
20a. Method of Disposition  1 ☑ Buriel 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Special	Removel from Stete St	Plece of Disposition (No cemetery, cremetery or John Epis	r other plac	('httroh'	July 19	20c. Loca 01nev		r Town, Stete
21. Signature of Funeral Service Lice 23a. Pert1. Enter the disease, or com- shock, or heart feilure. List only	I Byl	500 Un	ivers		. W.,Si	ilver		Approximate intervel Between Onset and Death
Immediate Cause (Finel disease or condition	a CHRONIC REN	NAL FAILURE						1 YEAR
resulting in death)	Dua to (	or es e consequence o	rf):					
	Dementia							i
Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury	Due to (	or es a consequence of	f):					
that initiated events resulting in death) Last	C. Due to (	or es e consequence of	f):					1
1050king in coatily East								
	d							1
Pert II. Other significant conditions of	contributing to death but not re-	sulting in the underlying	cause giv	ren in Pert I.	23b. Die	d tobacco us	as contribut	ts to the cause of death?
DEMENTIA					1	Yes 2	No 3□I	Probably 4K Unknow
					24a. Wa	s an autopsy formed?	24b.	. Ware autopsy findings available prior to completion of cause
					10	Yas 2KÖ	No	of death?
25. Was case referred to medical			-	26. Place of Deat				
axaminer?	Hospitel:	DER/Outpatient 3D 0	DOA Oth		- 0.	J-1 1 2 2 1	Other (So.	ecify)
27. Manner of Death  1 X Neturel 5 Pending 2 Accident Investigation	28e. Data of Injury (Month, Day Year)	28b. Time of tnjury	28c. Injur Wor		28d. Describe			,,/
3 Suicide 6 Could not b datarmined	00 - 51	nome, farm, street, fectorify)				(Street and i	Number or F	Rural Route Number,

To the Hospital or Attanding Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be deteched for use as the by Medical Certification: To Be Completed by Physician/Medical

29a. Certifier (Check only one) 29b. Signeture end

1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and dua to the cause(s) and menner stated.

29c. License number 29d. Dete signed (Month, Day, Year)

JULY 15, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DALJEET SINGH SIDHU, M.D.P.C. 1413 ANNAPOLIS ROAD #106 ODENTON, MARYLAND 21113

State Registrar

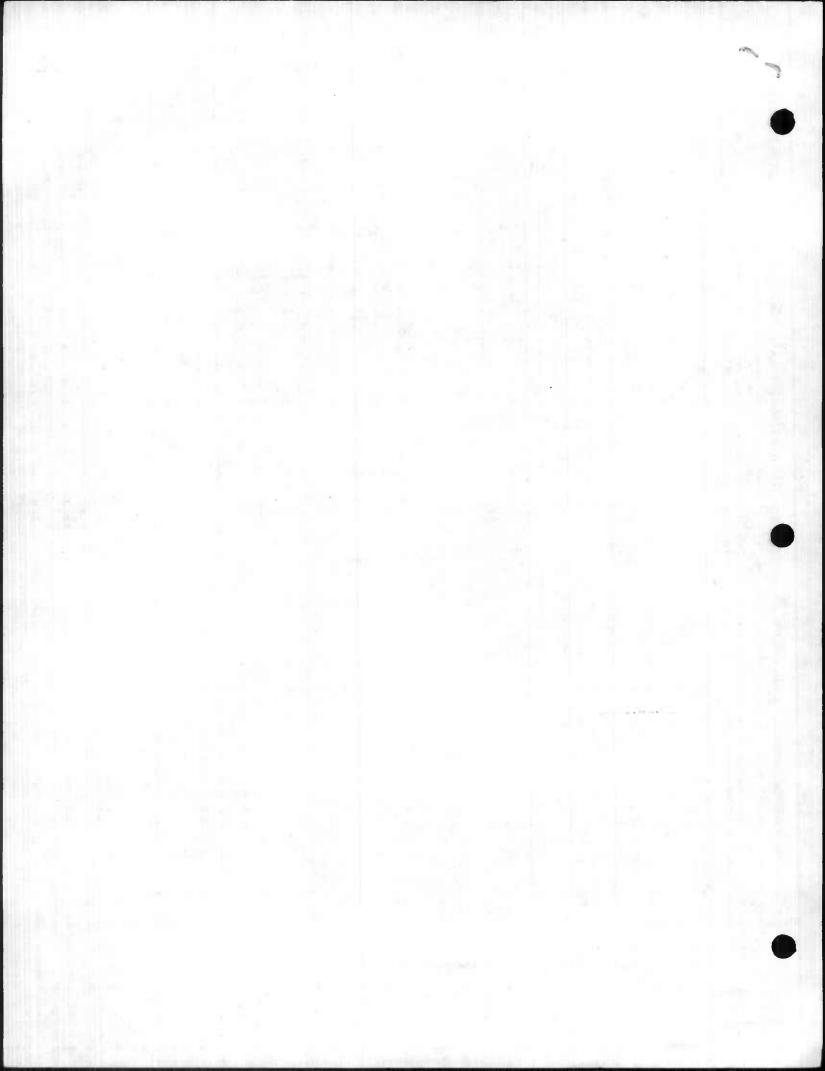
31. Dete tiled (Month, Day, Year)

JUL 2 0 1999

32. Registrer's Signetura

DHMH 16 Rev 6/95

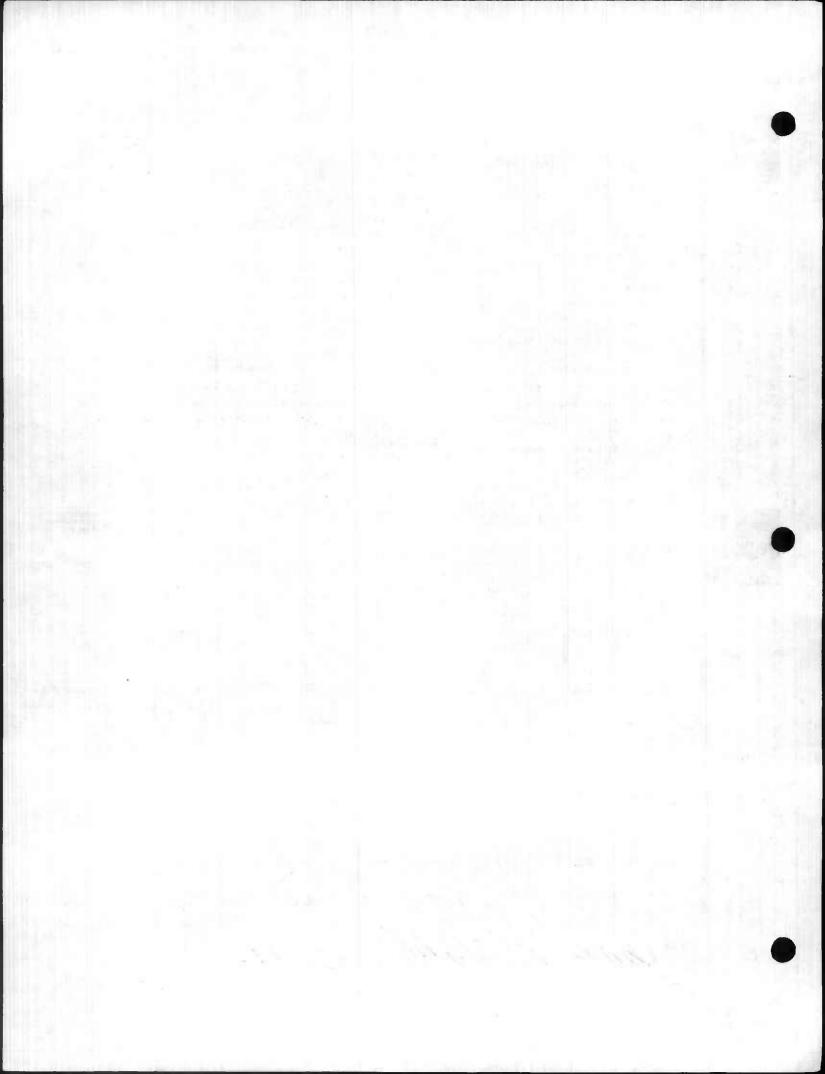
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 2 4 2 9 3

Projection    December   Mode							(	Certifica	ate of	Death		Reg. f	No.			
Examiner  Examin	Dhambala		1. Decedent's Nama (First, M.	iddla, Li	est)									Von	3. Time c	f Death
## Facility Names (Trace Technical Control of Death Manner Care — Chevry Chase    Manner Care — Chevry Chase   Section Service   Section Section Service   Section Service   Section Service   Section Service   Section Service   Section Service   Section Service   Section Secti		_	Gertrude C.	Be	1shaw										5:40	) AM
So Short Security Number   2. Saw   7. Ase, or yet and recording;   1. Higher 1 time   1. Dec.   1. Dec.   2. Dec.	(A)		4a Facility Nama (If not institu	ition, gi	va street and nu							ath	4c. County	of Death		
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Elementary Procurities (0-12)   Codespot (1-der 5-1)   Homemaker   Okrn Home	3 2 2	p	1 Nevar Married 2 N		Armed Fo	orcas? 2⊠No va	n U,S.				(Specify Yes or erto Rican, etc.)	No-	Black, Whita, etc.		elc.	
Elementary Procurities (0-12)   Codespot (1-der 5-1)   Homemaker   Okrn Home	72 ho	pete	15. Dece	dant's E	ducation		16a. D	ecedent's U	sual Occu	pation	undking.	16b.	Kind of B	usiness/Ind	ustry	
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Physician / Medical Examiner  202. Part Enter the disease, or complications the cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, increased as cause first responsible final responsible final disease or conditions. Approximate final responsible final disease or conditions. Approximate final responsible final disease or conditions. Approximate final responsibility final disease or conditions. Approximate final responsibility final disease or conditions. Approximate final responsibility final disease or conditions. Approximate final responsibility final disease or conditions. Approximate final responsibility final disease or conditions. Approximate final responsibility final disease or conditions. Approximate final responsibility final disease or conditions. Approximate final responsibility final disease or conditions. Approximate final responsibility final disease or conditions. Approximate final responsibility final disease or conditions. Approximate final responsibility final disease or conditions. Approximate final responsibility final disease or conditions. Approximate final responsibility final disease or conditions. Approximate final responsibility final disease or conditions. Approximate final responsibility final disease or conditions. Approximate final responsibility final disease. The final responsibility f		-		,11	(Hepitew)					LEEL, IN	T	7				
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Physician Medical Examiner  The standard and the standard	permit. Depart Import any in		Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Ma												ind 2	20910
Security   Security	Physician		23a. Part1. Entar tha disaasa shock, or haart failura.	or con	nplications that o ona cause on a	aused tha diach lina.	laath. Do no	t entar the m	node of dy	ing, such as card	liac or respiratory	arrest,			Approxima Intervel Be	etween
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25. Was casa referred to medical axaminer?    1	w require													COF	mpletion of	findings to cause
25. Was case referred to medical axaminer?   1		E									1[	Yes	2 No	10	Yes 2K	) No
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1   Natural   2   Accident   3   Suicide   4   Homicida   29e. Certifier   (Check only page)   29e. Certifier   29e. Medicat Examiner: On the pass of eyaminetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only page)   29e. License number   29e. Death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only page)   30. Namy and addrass of person who completed cause of death (Item 23a) (Type, Print)   James J. Foster, M.D., 5530 Wisconsin Avenue, # 925, Chevy Chase, MD 20815		0			Hospitai:	inpatient :	2 ER/Outp	atient 3	DOA O	han			6 □Oth	ner (Specif)	1)	
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29e. Certifier (Check only and address of person who completed cause of death (Item 23a) (Type, Print)  James J. Foster, M.D., 5530 Wisconsin Avenue, # 925, Chevy Chase, MD 20815  1. Certifying Physician: To the best-of fily knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.  29e. Certifier (Check only and State of Check only and State of	al or Attents at aborders of Director ed in by the	Certifica	3 Suicide 6 □ Cou	ld not b	28a. Place	of Injury - Ang, atc. (So	t homa, farm ecify)	, street, fac	tory, office	8				ber or Rura	l Route Nu	mber,
July 21, 1999  30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print)  James J. Foster, M.D., 5530 Wisconsin Avenue, # 925, Chevy Chase, MD 20815  31. Date fied (Month, Day, Car)  32. Registrar's Signatura	Hospit 24 hour Funers etsky fills		29e. Certifier (Check only 2 Medic	ying Pl	hysician: To the miner: On the bo	best of my asis of eyen nar stated.	knowledge, o inetion end/o	leath occum or investigat	ed at the t ion, in my	ima, data and pla opinion, death o	ce, and due to the courred at the time	e, date s	e(s) and me and place,	anner as st and due to	ated. the cause	(s)
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James J. Foster, M.D., 5530 Wisconsin Avenue, # 925, Chevy Chase, MD 20815	12	-	30. Name and addrass of pers	onwho	ompleted cause	e of death /	Item 23a) (To	roe, Print)	N	4/	7	1 0 4.	-, -1	, 100		
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Deeth 3. Time of Death Month Physician Rachel Elizabeth Boulden July 8:17 p.m. 1999 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Calvert Manor Healthcare Center Rising Sun Cecil 5. Sociel Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) **Funeral**  Birthplece (State or Foreign Country) Deys 1 M 200F Months Hours 219-10-8737 91 Director Feb. 16, 1908 Maryland Usuel Residence of Decedent 10a. State 10b. County 10c. City. Town or Location mast be notified at 10d. inside City Limits Maryland 1 ☐ Yes 2 No Cecil North East 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 33 Dr. Carr Road, Sunny Acres 21901 Негля 23а U.S.A. Funeral 12. Wes Decedent Ever In U.S. Armed Forces?

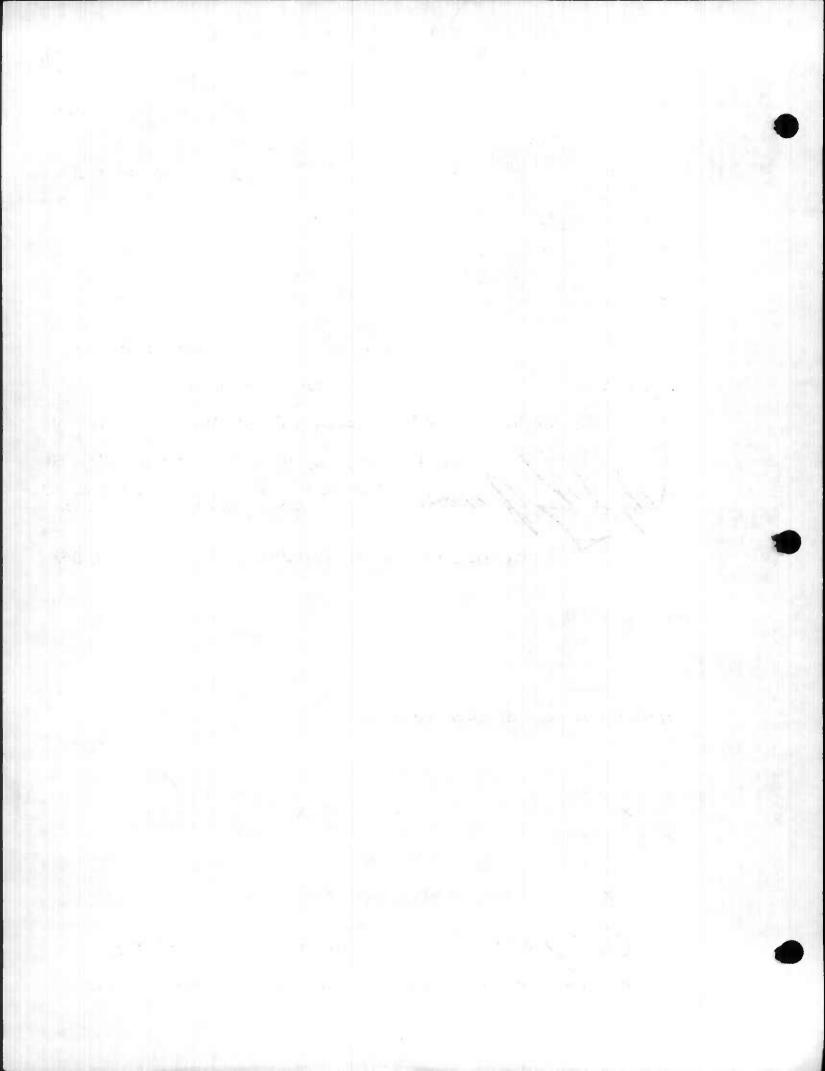
1 Yes 2 No If Yes, Give 14. Rece - American indien, Bleck, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) filed within 72 hours efter 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 natural, or 1 ☐ Yes ŽÍŽNo Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Domestic/Own Home other permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If Itam 27 is marked other any Injury or other traumatic events. 17. Fether's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumeme) Ernest Wills Craig Mary Ann Wooleyhan 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 2046 Audrey L. Polzer/Daughter 215 W. Greenway Boulevard, Falls Church, Virginia 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriei 2 □ Cremetion 3 □ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Bethel Cemetery/July 21, 1999 Chesapeake City, MD 21. Signeture of Fynerel Service Lice 22. Name end Address of Fecility Fellows, Helfenbein & Newnam Funeral Home, P.A. 226 E. Main Street, Cecilton, Maryland 21913 Approximate on each line. Intervel Between Onset end Deeth **Physician** /Medical immediete Cause (Final CONGESTIVE HEART FAILURE DAY diseese or condition resulting in death) Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Lest pue Due to (or es e consequence of): physician s the burial P.O. Box 68760, Physician/Medicai Due to (or es e consequence of) Pert li. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? signed by it 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION, SEIZURE DISORDER Records, þ Completed 24b. Were autopsy findings available prior to 24e. Wes en eutopsy performed? completion of cause of deeth? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No this certificate of Vital To the Hospital or Attanding Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director; to Be 25. Wes case referred to medical 26. Piece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) Certification: To 1 Yes 2 No 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Division 5 Pending investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, Stete) 4 - Homicide 12 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) end menner steted. Medicai 29a, Certifier (Check only one) 29b. Signature end title of cartifier 29c. License number 29d. Dete signed (Month, Dey, Year) 3 30. Neme and address of person who completed ceuse of deeth (Item 23e) (Type, Print) DHANJANI MD 622 5. UNION AVE, HAVRE DE GRACE, MD 21078

132. Registrer's Signeture 31. Dete filed (Month, Day, Yeer)

19. Sparks

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Stephen Ay Bollman, Sr. 4:45 a.m. July 12, 1999 /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Death Examiner 8. Data of Birth (Month, Dey, Year) 201 River Road (Residence) Chestertown Queen Anne's 5. Social Security Number If Under 1 Year If Undar 24 Hrs. 7. Age (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** Min 1 X M 2 □ F Months Days Hours 55 Yrs. 1944 Maryland Director 217-40-7815 Usual Residence of Decedent permit. Pagas 1 and 2 should be filed within 72 hours aftar death with the Meryland Department of Health and Mental Hygiena. Important: if Item 27 is marked other than "natures", or Items 23a or 28a-f show eny Injury or other treumatic event, the Medical Experime, must be nutried. 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No Directo Maryland Queen Anne's Chestertown 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? 21620 201 River Road USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notit Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian. 11. Maritel Status Black, White, etc. 1 Naver Married 2 Married 1 ☐ Yes ② No If Yes, Give Year or Dates: 1 ☐ Yes XXNo Specify: Baltimore, Maryland 21215-0020 White p 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) General Manager Rental Mart 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middla, Last) Roger Thurman Ruth Elizabeth Ay 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Stephen Ay Bollman, Jr. 321 Truslow Road, Chestertown, MD 20b. Place of Disposition (Neme of cematery, cremetory or other plece) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Paul's Cemetery 7/15/99 Chestertown, Maryland 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility Fellows, Helfenbien & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, MD 21620 that caused the daeth. Do not enler the mode of dying, such as cardiac or raspiratory arrest, use on each line. 23a, Part1. Entar the disagree, or comshock, or heart tailure. List only Approximate tnterval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting In deeth) 1 ans 10 Ca Examiner Due to (or as a conse Examiner requires that the death certificate be executed physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence ot): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence ot): 88 for usa signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 Yes ģ 24b. Were eutopsy tindings available prior to completion of cause of deeth? 24a. Was an autopsy Completed page 2 s certificata hes 1 □ Yes 2 □ No Hospital or Attending Physicien: funerel director. 25. Was cese reterred to medical exeminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Yes 5 Nesidence 8 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27 Menger of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 28e. Date of Injury (Month, Dev Year) Neturel 5 Pending 1 ☐ Yes 2 Accident investigation after daath Director: 6 Could not be determined 3 Suicide 28t. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Certifying Physician: To tha best of my knowledge, death occurred at the time, data end place, and due to the cause(s) end manner as stated.

2 Medicat Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier edica

29c. License number

ause ot deeth (Item 23e) (Type, Print)

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32. Registrer's Signeture

29d. Data signed (Month, Day, Year)

State Registrar

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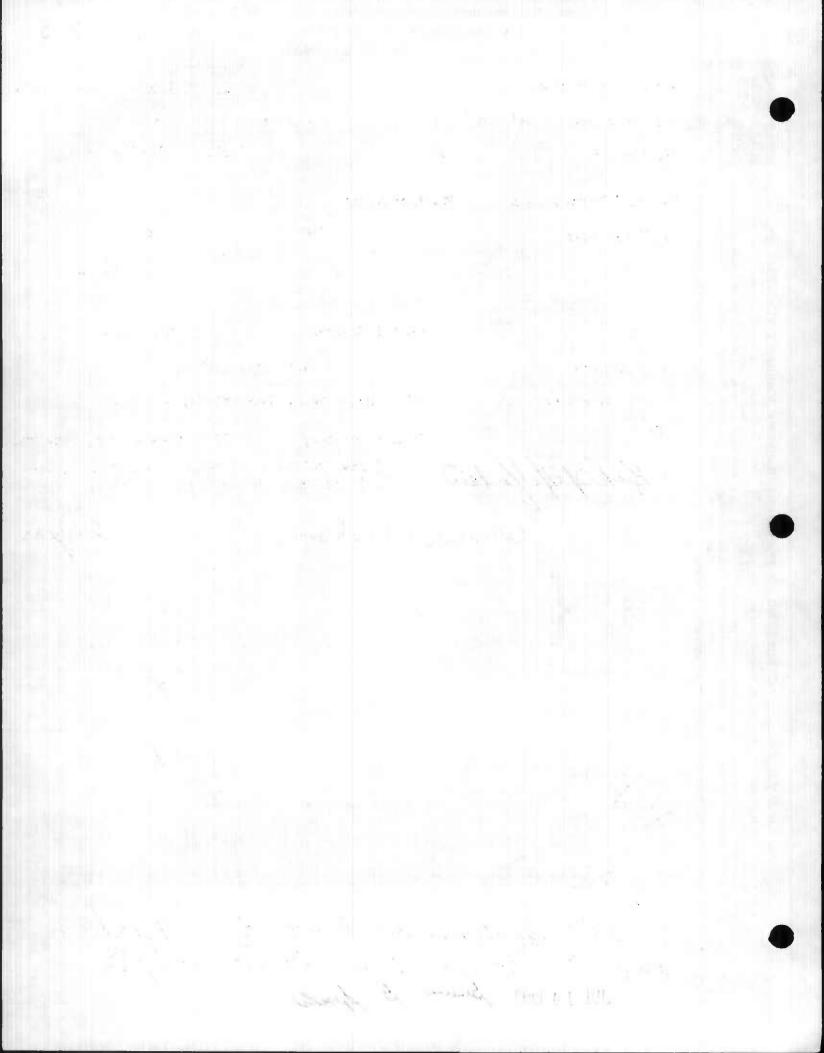
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29b. Signapaire and title of certifie

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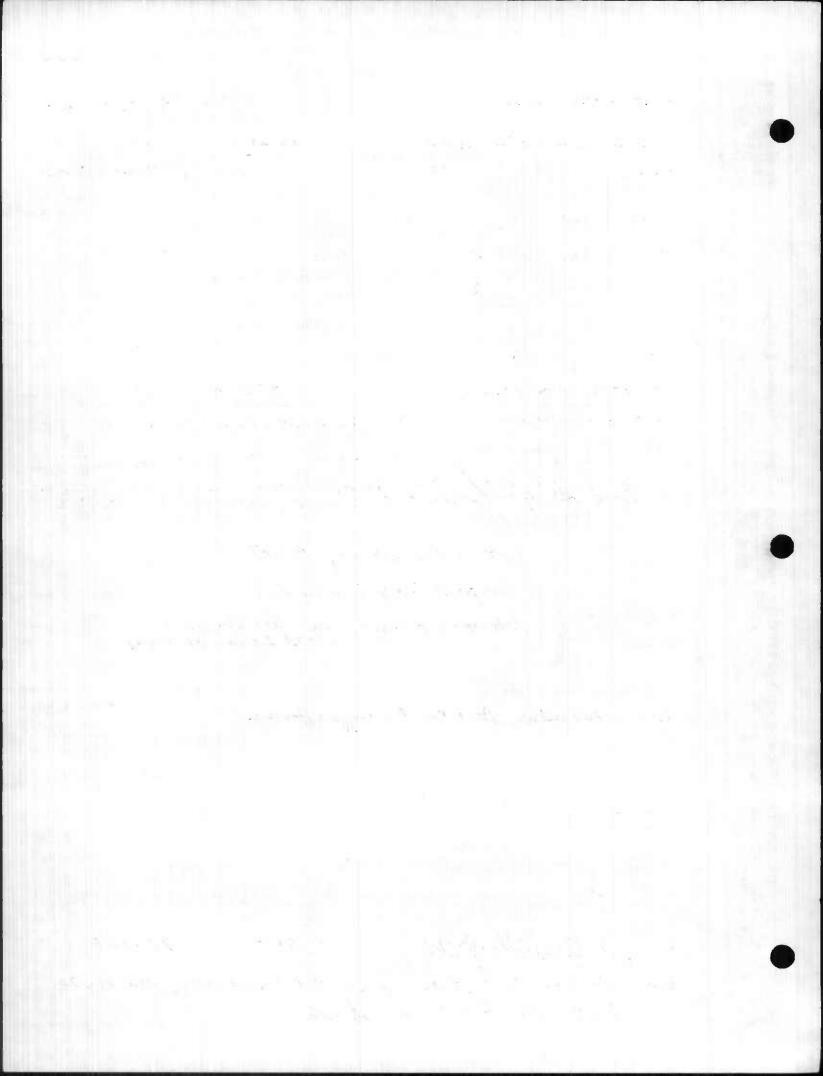
and address of person

ith Dev. Year)



State of Maryland / Department of Health and Mental Hygiene 99 24296

					Cer	tificate of	Death		Reg. N	lo.		
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		Kent and Queen	Anne's	Hospital			Chest	ertown		Ken	t	
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lend w		10a. Stete 10b. County		10c. City,	Town or Loc	ation					1	0d. inside City Limits
f ah	ō	Maryland Kent		1	Vorton							1 ☐ Yes 2X No
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€ 8	ä	10e. Street and Number				10f. Zip Coda			Tog. C	itizen or v	What Coun	try r
23a	<u>a</u>	12630 Still Pond	Creek Ro	ad		2167				USA		
UZO urs efter death with the Merylen al', or items 23s or 28s-f ahow Examinet must be notified at	Funerai	11. Marital Status	12. Was Dece	deni Ever in U,S. ces?	13. W	les Decedent of H Yes, specify Cuba	lispanic Origin'i an, Mexican, Pr	(Specify Yes or Nuarto Rican, atc.)	10-		e - Americ	
of of the		1 Never Merried 2 Married	1 ☐ Yes If Yes, Give	2 <b>X</b> No		☐ Yes 20XNo	Specify:				Whit	
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C = OI L		Mary Ellen Tyson/	Sister		1100	Regiment	Drive,	, N.W., A				
8625		20e. Method of Disposition	Removel from S	20b. Pla	ce of Dispos n <i>etery</i> , crem	ition (Neme of etory or other place	ce)	Dete	20c.	Location -	City or To	wn, State
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box 600 000, and be seen the confidence of the c	/Medical Examiner	Immediate Ceuse (Finel diseese or condition resulting in deeth)  Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that intitled events resulting in death) Lest	b. Ren	Due to (or e	se e consequences e c	mary  uence of):  Fair  uence of):  Cauno  uence of): with	Arner lure mento	Liver, C	PRIT	fuar	7	Onsat and Death
	Physician	Pert II. Other significant conditions	contributing to dea	ath but not result	ing in tha un	derlying ceuse giv	en in Pert i.	23b. Di	d tobac	co use co	ntribute to	the cause of death
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Physicia this cert	70	1 ☐ Yes 2 ☑ No	Hospital: 1 1	patient 2 El	R/Outpetient	3□ DOA Oth	er: 4 Nursin	ng Home 5 □ Re	sidence	6 □Oth	ner (Specify	1)
	Ë	27. Menner of Death 1 ☑ Naturel 5 ☐ Pending	28e. Dete of (Month)	injury 2 Dev Year)	8b. Time of Injury	28c. injur Wor	y at k?	28d. Describ	e how in	jury occur	red	
I or Attending efter death. Director: After d in by the fune	atic	2 ☐ Accident investigati		me		M 1 🗆	Yes 2 □ No					
or Attender death of the death	Fic	3 Suicide 6 Could not	a 200. Place	of Injury - Al hom	a, ferm, stre	el, fectory, office		28f. Location City or 7	(Street	end Numb	ber or Rura	I Route Number,
2 4 4 6	Certification:	4 D Hornicos	Dullgin	g, etc. (Specify)				Only of 1	OMII, OII	110)		
To the Hospital or within 24 hours efter To the Funersi Dir completely filled in	edicai (	29a. Certifier 1 Certifying F (Check only one) 2 Medicai Exi	hysician: To the barrinar: On the barrinar	sis of examinetio	edge, death n and/or inv	occurred at the tir estigetion, in my o	ne, date end pi pinion, death o	lece, and due to the	e cause e, date e	(s) end ma end place,	anner as s and due to	tated. the ceuse(s)
within 2 To the comple	Me	29b. Signature and title of certifier		-) - 4 (1)		29c. Licens	e number		29d. [	ate signe	d (Month,	Day, Year)
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	TQ	410-000	ww	yn YW E	١.	120	200	/	-	14	177	
		30. Neme end address of person who		of deeth (Item 2	?3e) (Type, F	Print)	1			2	,	
		Whole ARRAS.		15,948,	WASLE	ug Fm /	TYZ, CI	Hesker to	wn	, m	d 21	620
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Regis	trar	JUL U7	1999 🗡		Ø.	spark	2					



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. Amended#26,7/20/99cac,KentCo. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year **Physician** Grace May 1999 1149 July 18 /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kent and Oueen Anne's Hospital Chestertown Kent If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
November 22, 1908 Maryland 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 M 2 X F Months 214-32-0424 90 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Maryland Kent Rock Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23e or 2 203 Chesapeake Villa Funeral 21661 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Status 12. Wes Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: r than "natural", or iten the Medical Examiner Biack, White, etc. 1 Never Merried 2 Married 1 Yes 2 No Specify: Maryland 21215-0020 Specify: White þ 3XXWidowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Bueiness/Induatry 15. Decedent's Education (Specify only highest grade completed) Hyglens. Elementary/Secondary (0-12) Cotlege (1-4or 5+) Homemaker 12 Own home 18 Mother's Name (First Middle Maiden Sumame) 17. Fether's Name (First, Middle, Last) Pages 1 and 2 should be fit ment of Health and Mental H ant: If Item 27 is marked oth Be Theodore Bosley Florence L. Sherfey la m 19a. fnforment's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Nelson Culley, Jr./Grandson 5625 Boundary Avenue, Rock Hall, Maryland 21661 Baltimore, 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removat from State Department ( Important: If 4 ☐ Donation 5 ☐ Other (Specify) Pauls cemetery 7/21/99 Rock Hall, MD 21. Signeture of Fune ai Servica Licansee 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 23a. Part 1. Enter the disease, or compilications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest,

Approximate the disease, or compilications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest,

Approximate the disease, or compilications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest,

Approximate the disease, or compilications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final 'ARDIO Pulmonans disease or condition resulting in death) Examiner Examiner physician and the burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last certificate be axec Box 68760. Physician/Medical Due to (or as a consequence of): SB USB signed by the a Part tl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yee 2 No 3 Probably 4 34hknown structine Pulmorary þ 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes en autopsy Completed of Confertine Heart Failure, 15 ste Britler e Carcinoma 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No certificata 25. Was case referred to medical examiner? Division of Vital Be 28. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 25XER/Outpatient 25X DOA Other: 4 Mursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 No this funeral 27. Manner of Death 28c. tnjury at Work? 28d. Describe how injury occurred 28e. Dete of Injury (Month, Dey Year) 28b. Time of Certification: 1 Watural 5 Pending after death. Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident rone 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide ò Hospital 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end manner steted. To the I within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed caused death (Item 23a) (Type, Print)

WAShington

948

Ms.

32. Registrar's Signeture

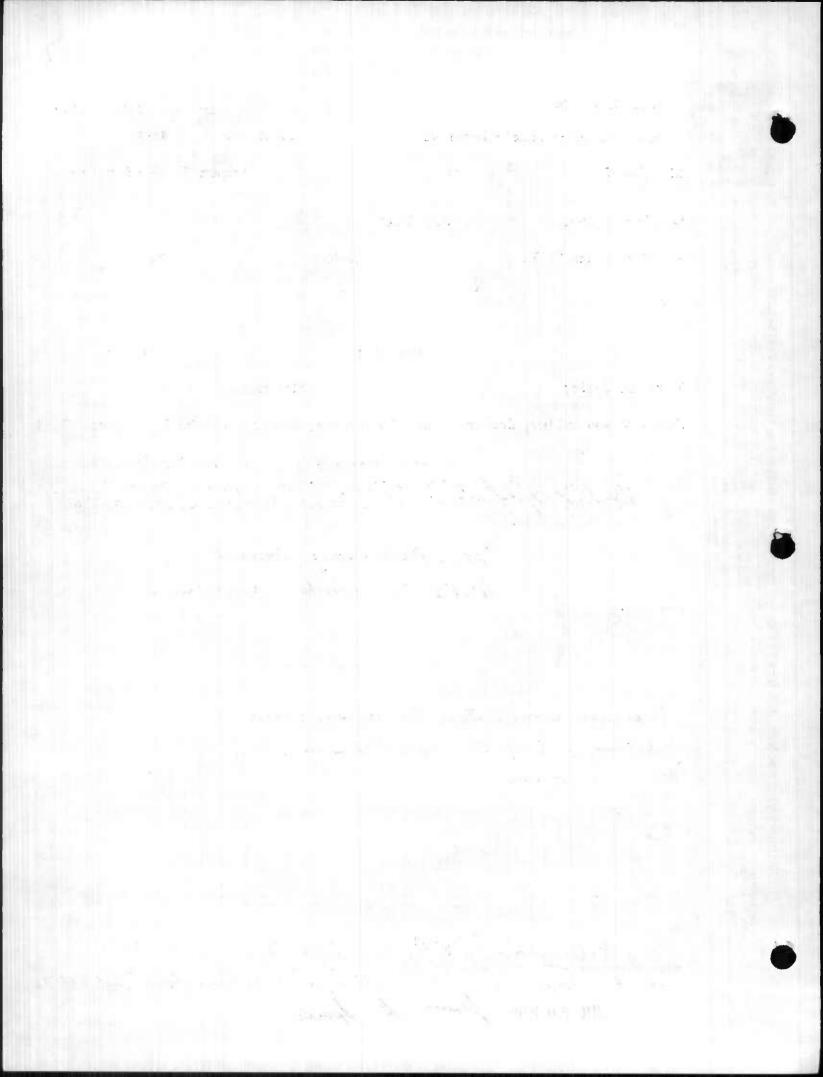
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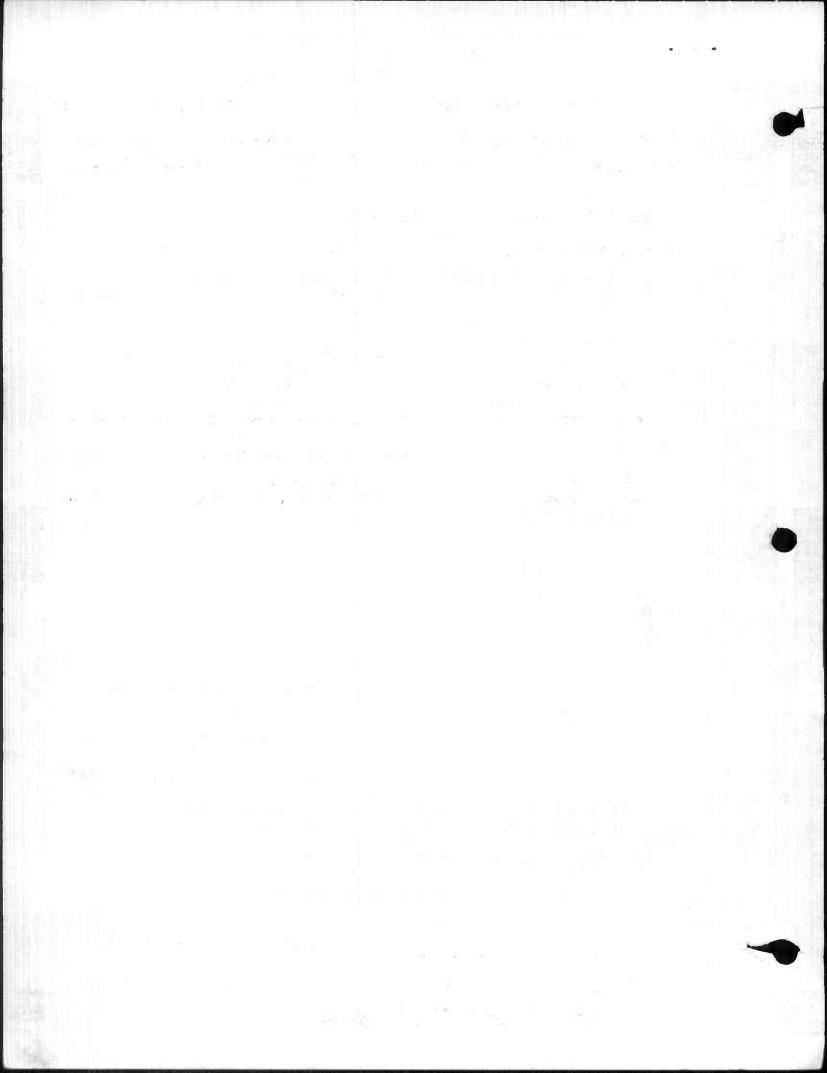
31. Date filed (Month, Day, Year)

Ave, Chesteadown West 21620

State Registrar



		Sta  1. Decedent's Neme (First, Middle, Last)	te of Mar		epartme Certifica		lealth and Death		Reg. No.		L; 298
Physician /Medical Examiner	ŀ	E11a Moo		ramble			4b. City, Town, or	78.07	8 , Dey 1 9 9 4c. County	9 <sup>Yeer</sup>	6:55 PM
⊏xaminer	ı	Dorchester General H					Cambr			rches	ster
Funeral Director		5. Social Security Number 6. Sex 1 □ M 2(	7. Age (	In yrs. lest birtho	Months	T 1 Yaar Days	If Under 24 Hrs Hours Min.	8. Data of Birth			oleca (Stata or Foreign of Land
and was	-	Usuel Residence of Decedent 10a. State 10b. County	1	IOc. City, Town o	r Location					1	0d. Inside City Limits
r 28a-f sho notified at		Maryland Dorchester			hops H	ead					1 □ Yes 2/□XNo
or 28e-f s be notified Director		IOe. Street and Number			10f. Z	ip Code		1	10g. Citizen of \	What Coun	itry?
23a unit b		1914 E. Tedious Cree	k Road			2167	2		US		
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	-	15. Decedent's Education (Specify only highast grade comp Elementery/Secondery (0-12) Coi	leted) lege (1-4or 5+)	(G	ecedent's Usu live kind of w le. DO NOT I	uai Occup ork done use retired	etion during most of wo	rking	16b. Kind of Bi	ualness/Ind	Justry
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and Men s marks sumatic		19e. informent's Neme/Reletionship (Type, Prin	nt)	19b. M	eiling Addres	s (Street	and Number or Ru		r, City or Town.	Stete, Zip	(Code)
Health and Mer tem 27 is merks other traumetic		Clara C. Hurley	Sister								land 21613
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Depart Import any inj once.		21. Signature of Funerel Service Ucensee					ss of Facility eral Homo Street		a Mary	land	21613
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signed by the attending id be detached for use a detached for use a detached for use and by Physician/M		Chonony Heart	Pise	Pare				1 🗆 Y	- V		bably 4 Unknown
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on the		29b. Signatura and title of certifiar	menner stete	d.	29	c. Licans	e number	2	29d. Data signe	d (Month.	Day, Year)
To the comple		1 0000	e. e			-	111284		7.19		
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State	3	11. Dete filed (Month, Dey, Year)	32. Registrer's	Signeture	4	/					



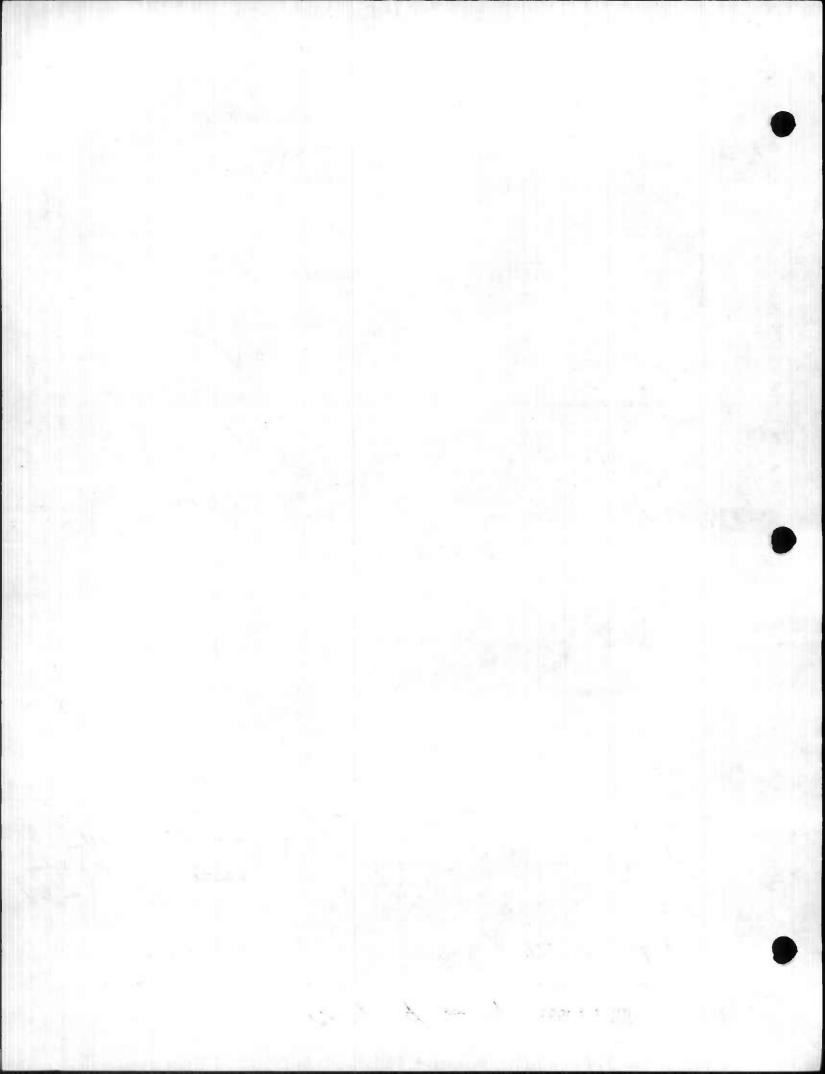
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B 18	10a. State	10b. County		10c. City	y, Town or Location	on				10d. In	side City Limits
or 28s-1 s be notified Director	MD	Anne	Arunde	l Ar	butus					11	☐ Yes 2€ No
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kiner must kiner must Funeral	11. Merital S	itatus	12. Was Deceden Armed Forces	t Ever in U,	S. 13. Wes	Decedent of I	Hispanic Origin? ( pan, Mexican, Pue	Specify Yes or N	0- 14. Ra	ce - American Inc	lien,
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State Registrar

JUL 2 0 1999

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31. Dete filed (Month, Day, Year)
32. Registrer's Signeture

111 Penn Street, Baltimore, Maryland 21201



State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 3. Time of Death 1 Decedent's Nama (First Middle Last) 2. Data of Death **Physician** JAMES COOKE 1999 JULY 15 1500 · /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ANNAPOLTS AN If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Dey, Year) ANNE ARUNDEL MEDICAL CENTER ANNE ARUNDEL 5. Social Sacurity Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1**⊠** M 2□ F 75 216-16-4096 Yes Director MARCH 18 1924 MARYLAND Usual Rasidance of Dacedant with the Meryland 10d. Insida City Limits 10a Stata 10b. County 10c. City, Town or Location must be notfied at 1 Was 2 No ANNAPOLIS MARYLAND ANNE ARUNDEL Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? US 21401 202 CLAY STREET Funeral death 13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puano Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. Item 27 is marked other than "natural", or Items other traumatic event, the Medical Examiner m. 12. Was Decedant Evar In U,S. Armed Forcas? 1 ☐ Yes 2 ☐ No If Yas, Give 11. Marital Status filed within 72 hours after 1 Navar Married 2 Married 1 Yas 2 No Specify: Specify: BLACK þ 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grede completed) Elementary/Secondary (0-12) Collaga (1-4or 5+) Pages 1 end 2 should be filed with nent of Health end Mental Hygiene. nnt: If Item 27 is marked other than 1ry or other traumatic event, the M 12th TRUCK DRIVER BFI 18. Mothar's Nama (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Be ANNA G. JONES JAMES E. COOKE 19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) MARTHA L. COOKE (WIFE) 202 CLAY ST. ANNAPOLIS, MD. 21401 Baltimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Burial 2 Cramation 3 Ramoval from Stata 4 Donation 5 Other (Specify) permit. Page Department of Important: If any Injury or ANNAPOLIS MEM. GARDENS 7/20/99 ANNAPOLIS, MD. 22. Nama and Addrass of Facility 821 WEST STREET 21. Signatura of Funaral Sarvice Licensaa ANNAPOLIS , MD. 23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrast, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in deeth) Examiner Dua to (or as a consequence of) Examiner disease arles physician and the buriel-transit certificate be executed Sequantially list conditions, if any, leading to immediata causa. Enter Undarlying Causa (Disaasa or Injury Due to (of as a consequence of Division of Vital Records, P.O. Box 68760. weter Physician/Medical Dua to (or as a consequence of) that initiated avants rasulting in daath) Last 80 USB signed by the a d be deteched f Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Onknown ò 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy Completed pege 2 : 1 Yas 2- No 1 ☐ Yas 2 ☐ No certificate funeral director, 25. Was casa rafarrad to medical axaminar? 26. Placa of Daath (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) Hospital: 1 ☐ Inpatiant 2 ☑ ER/Outpatient 3 ☐ DOA 2 1 Yes 2NNo After this 28a. Data of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Dascribe how Injury occurred 27. Manner of Death 28b. Tima of Certification: or Attending 1 Natural 5 Pending 1 ☐ Yas 2 ☐ No deeth. investigation 2 Accidant 24 hours efter deel Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicida 28e. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify) filled in by 4 Homicida Hospital 29a. Certifian 1 Certifying Phyelclan: To the best of my knowledge, death occurred et the time, dete end place, and dua to the cause(s) and manner es stated edicai (Check only one) 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, end due to the cause(s) and manner stated. To the within 2 To the 29b. Signature and title of offittle 29c. License number 29d. Data signed (Month, Day, Year) 0 25499 famel 14 fm m> mand address of person who completed cause of death (Itam 23a) (Type, Print) Cochrane Dr Admira 180 Ames Kuppel

State Registrar 31. Data filad (Month, Dey, Year)

JUL 1 9 1999

32. Pégistrer's Signatura

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State of Maryland / Department of Health and Mental Hygiene Amena #31,7/21/99, BMW, Montg. Co Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day **Physician** 18, GEORGE SAMUEL CHESKY JULY 1999 7:30 AM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SUBURBAN HOSPITAL BETHESDA MONTGOMERY If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 10 M 2□ F 578-01-7909 88 Director AUG. 6, 1910 PENNSYLVANIA Usual Residence of Decedent the Mandand 10a. Stete 10c. City, Town or Location r 28a-f ahow 10b. County 10d. Inside City Limits 1 Ves 2 □ No Director MARYLAND MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Transition 11706 GOODLOE ROAD 20906 UNITED STATES Funeral death 14. Race - American Indian, Bleck, White, etc. Пета 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 ☐ Never Merried 2 Married Specify: WHITE 21215-0020 6 1 ☐ Yes 2 ☐ No Specify: by 3 □ Widowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) OFFICE CLERK PRINTING Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental Health and Mental Health if item 27 is marked oth Be FRED CHESKY LOUISE HABERLY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) nt of Health a H frem 27 le or other tre MILDRED E. CHESKY 11706 GOODLOE RD. SILVER SPRING MARYLAND 20906 (WIFE) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 KD urial 2 Cremetion 3 Removal from State ment / 7-20-99 4 ☐ Donetion 5 ☐ Other (Specify) JOHNS-FOREST GLEN SILVER SPRING, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HINES-RINALDI F. H. INC. 11800 NEW HAMPSHIRE AVE. SILVER SPRING MD. 20904 Pert1. Enter the disease, or complications that caused the ceath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert feilure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final diseese or condition resulting in death) PNEUMONIA Examiner Due to (or as a consequence of) Examiner CONGESTIVE HEART FAILURE The law requires that the death certificate be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last and Due to (or as a consequence of) Box 68760. PYLORIC STENOSIS Physician/Medical the Due to (or as a consequence of) 10 080 signed by the all d be detached for Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? should Completed peed hes page 2 1 ☐ Yes 2 WNo 1 ☐ Yes 2XXVo certificate of Vital Attending Physicien: funeral director, 25. Wes case referred to medical exeminer?
1 ☐ Yes 2 ☒ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Certification: To this 27. Menner of Death 28b. Time of 28d. Describe how injury occurred After 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? Division 1 XNetural 5 Pending or Attending after death. 1 Yes 2 No investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, atreet, fectory, office building, etc. (Specify) In Dy 4 Homicide pelli Hospital
 24 hours a
 Funeral Medical 29e. Certifier Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner steted. To the To To the F 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 99 1-27660 mouran 20 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 20895 KENSINGTON ALPANA GOSWAHI CONNETICUT AVE M.D. 10901 31. Dete filed (Month, Dey, Year) 32. Registrar'a Signature State JUL 2 1 1999 souls

**DHMH 16 Ray 6/95** 

Registrar



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Date of Deeth July 15, 1999 12:25 PM Mary Lou Chory 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street end number) 4c. County of Deeth Shady Grove Adventist Hospital Rockville MD Montgomery | If Under 24 Hrs. | 8. Date of Birth | Hours | Min. | See 17, 1934 If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Months Days 1□ M 2□ F Yrs. Tennessee 412-50-4827 65 Usuel Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. tnside City Limits 1 Yes 2 No Derwood Maryland Montgomery 10e Street and Number 10f. Zip Coda 10g. Citizen of What Country? 20855 United States 6901 Horizon Terrace 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yas, Give Year or Detes: Was Decedant of Hispanic Orlgin? (Specify Yes or No-If Yas, specify Cuben, Mexicen, Puerto Rican, etc.) 14 Bace - American Indian Bleck, Whita, etc. 1 Never Married 2X Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maldan Sumeme) 17. Fether's Nema (First, Middle, Last) Mary Elizabeth Cheatham Jack Greenie 19e. Informent's Neme/Ralationship (Type, Print) 19b. Melling Addrass (Street end Number or Rural Routa Number, City or Town, Stata, Zip Code) Derwood, MD 20855 6901 Horizon Terrace, Joseph L. Chory, husband 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20a. Mathod of Disposition Dete July 19 1 Buriel 2 Cremetion 3 □Remon from State Gate of Heaven Cemetery 1999 Silver Spring, newl Service Licer 22. Neme end Address of Facility DeVol Funeral Home 20877 10 East Deer Park Dr., Gaithersburg, MD esa, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, a. List only ona causa on aach lina. Approximata Intervel Between Onset and Deeth METASTATIC NON SMALL CALL CARCINOMA OF Immediate Causa (Final diseese or condition rasulting in death) Due to (or es e consequance of) Due to (or es a consequence of). Due to (or es e consequence of)

**Physician** /Medical Examiner

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After or Attending

after death.

Hospital 24 hours Funeral

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Certification:

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certificata be executed physician and the burial-transit

Box 68760.

Division of Vital Records, P.O.

any injury or c

Physician

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Examiner

Director

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Completed

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**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours efter death Department of Health and Mental Hygiena. Intern 27 is marked other than "natural", or items 23.

Baltimore, Maryland 21215-0020

with the Manylend

Examiner Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Physician/Medical

Pert II. Other significant conditions contributing to deeth but not resulting in the undariying causa givan in Part I. HRUNIC OBSTRUCTIVE FLUMONARY DUKASK 23b. Did tobacco use contribute to the cause of death? Y00 2□ No 3 Probably 4 Unknown

24a. Wes an autopsy performad?

24b. Ware eutopsy findings aveilable prior to completion of cause of death?

1 Yes 2 No

1 TYes 2 No

25. Was cese referred to medical exeminer? 26. Pleca of Deeth (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 28h Tima of 28d. Describe how injury occurred 28c. Injury et Work?

27. Manner of Death 5 Pending Investigation 2 Accident 6 Could not be determined 3 ☐ Suicide

28e. Plece of Injury - At home, ferm, atreet, fectory, office building, atc. (Specify)

1 Yes 2 No

28f. Location (Streef end Number or Rural Route Number, City or Town, Stata)

29a. Certifier (Check only one)

4 Homicida

Certifying Physician: To the best of my knowledga, daath occurred at tha tima, data and place, end dua to the ceusa(s) and manner as stated.

Madical Examiner: On the basis of examination end/or invastigation, in my opinion, deeth occurred at the time, date end place, and dua to the cause(s) end menner stated.

29b Signature end title of certified d ceuse of death (Item 23a) (Type, Print)

29c. License number

29d, Date signed (Month, Dev. Year)

DRIVE KOCKVILLE MD20850

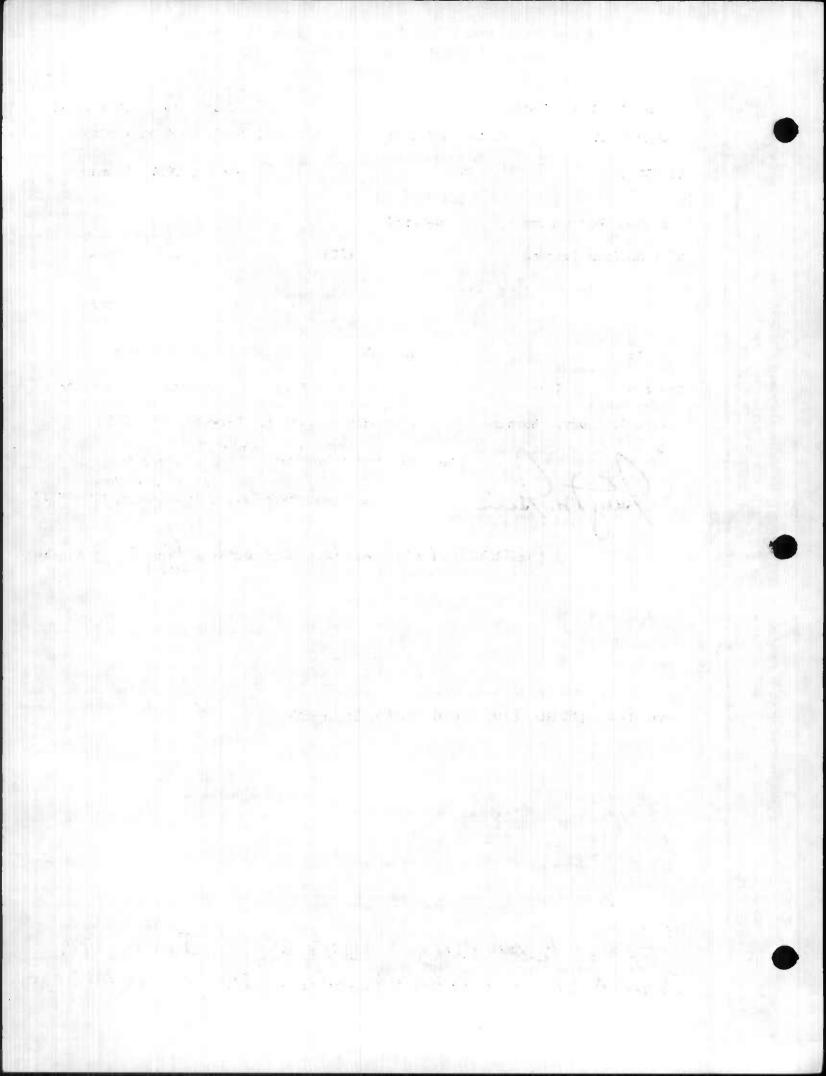
filed (Month, Dey, Year)

32. Registrer's Signeture

20 JUL 1999

State Registrar

**DHMH 16 Rev 6/95** 



State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death Reg. No 1. Decedant's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death July 19, 1999 **Physician** 7:19 AM Magda Comsky /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring 412 Kimblewick Drive Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Aga (In yrs. last birthday) **Funeral** Days Months Hours 1□ M 2\ F 109-16-2203 Yrs Director March 3, 1910 89 Jugoslavia Usual Rasidence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or flams 23a or 28a-f shorter than Medical Examiner must be notified at 1 Yas 2 No Director Florida Palm Beach West Palm Beach 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 2800 North Flagler Drive 33407 United States Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. filed within 72 hours after 1 Nevar Married 2 Married 21215-0020 1 ☐ Yas 2 No Specify: Specify: ğ 3 ☑ Widowed 4 ☐ Divorced Yaar or Datas: white Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Hygiene. Elemantary/Secondery (0-12) Collega (1-4or 5+) Accountant Real Estate 4 other Baltimore, Maryland 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nema (First, Middle, Maiden Sumema) permit. Pages 1 and 2 should be fill Department of Health and Mentel Hy Important: If Item 27 Ie marked oth any Injury or other traumatic even Be Robert Rado Ida Bun 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Miriam Gray 412 Kimblewick Drive, Silver Spring, Maryland 20904 (daughter) 20b. Place of Disposition (Nama of cematery, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Buriai 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 7/20/99 Beltsville, Maryland 22. Name and Address of Facility
Rapp Funeral Services, P.A. 21. Signature of Funeral Sarvious License M00956 933 Gist Avenue, Silver Spring, Maryland 20910 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heer feilure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final disaasa or condition resulting in death) 9 months CEREBROVASCULAR ACCIDENT Examiner Dua to (or as a consequence of): Examiner CEREBROVASCULAR DISEASE years The law requires that the deeth certificate be executed bunial-fran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue Dua to (or as a consequence of): Box 68760. physician Physician/Medical the Due to (or es a consequence of) 88 980 for Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. the 1 Yaa 2 No 3 Probably 4 Unknown signed by ATRIAL FIBRILLATION þ of VItal Records, 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? this certificate has 1 ☐ Yas 2 No 1 Yas 2 No Physician: director. Be 25. Was case rafarred to medical axeminer? 26. Place of Death (Check only ona) Daughter's Other: 4 Nursing Home 5 Residence 6 Nother (Specify) residence Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Yas 2X No funeral 27. Mennar of Death 28d. Describe how injury occurred 28a. Dela of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? After 5 Panding Invastigation or Attending Division 1 Netural s after death. 1 Yas 2 No 2 Accident the 28a. Plece of Injury - At home, farm, street, factory, office building, atc. (Specify) 6 Could not be datarmined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Steta) 3 4 | Homicide filled in To the Hospital within 24 hours a To the Funeral C Hospital 10 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, deta and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. 29a. Certifier edical completely (Check only one) 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signatura and D10287 July 19, 1999 In 40 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Brandis Marsh, M.D., 106 Irving Street, NW, #116, Washington, DC 20010 31. Data filed (Month, Day, Year) 32. Registrar's Signatura

**DHMH 16 Ray 6/95** 

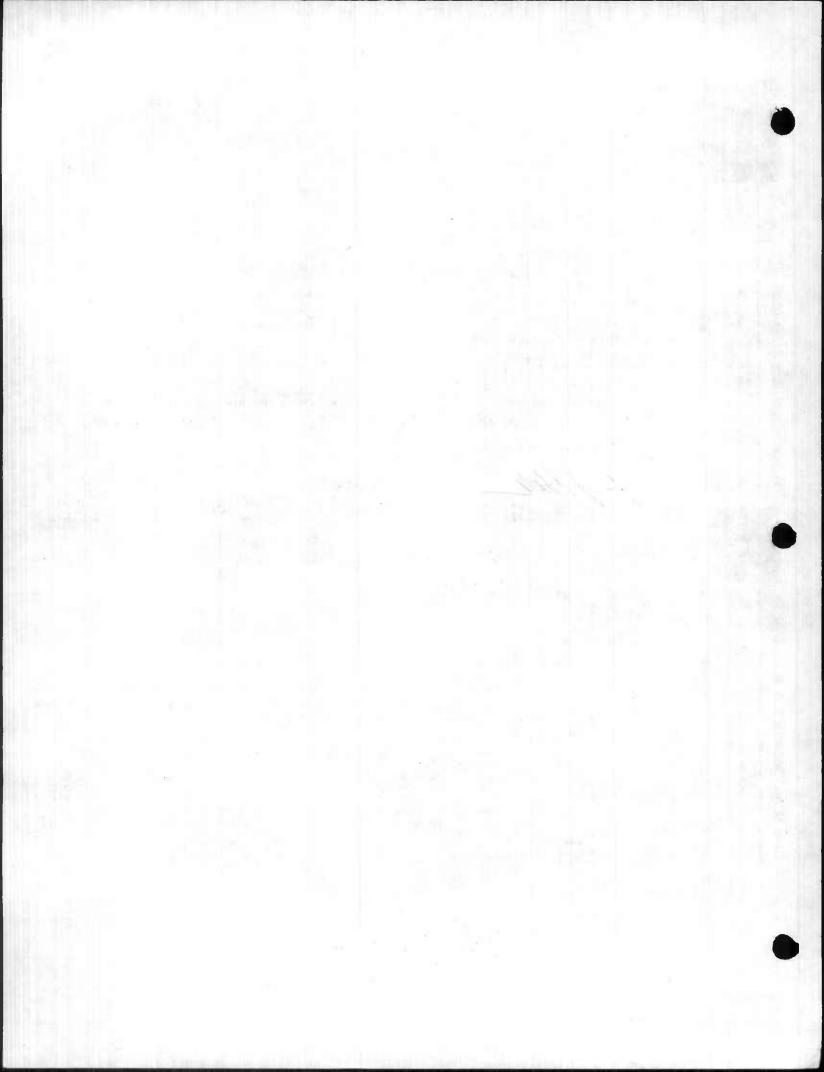
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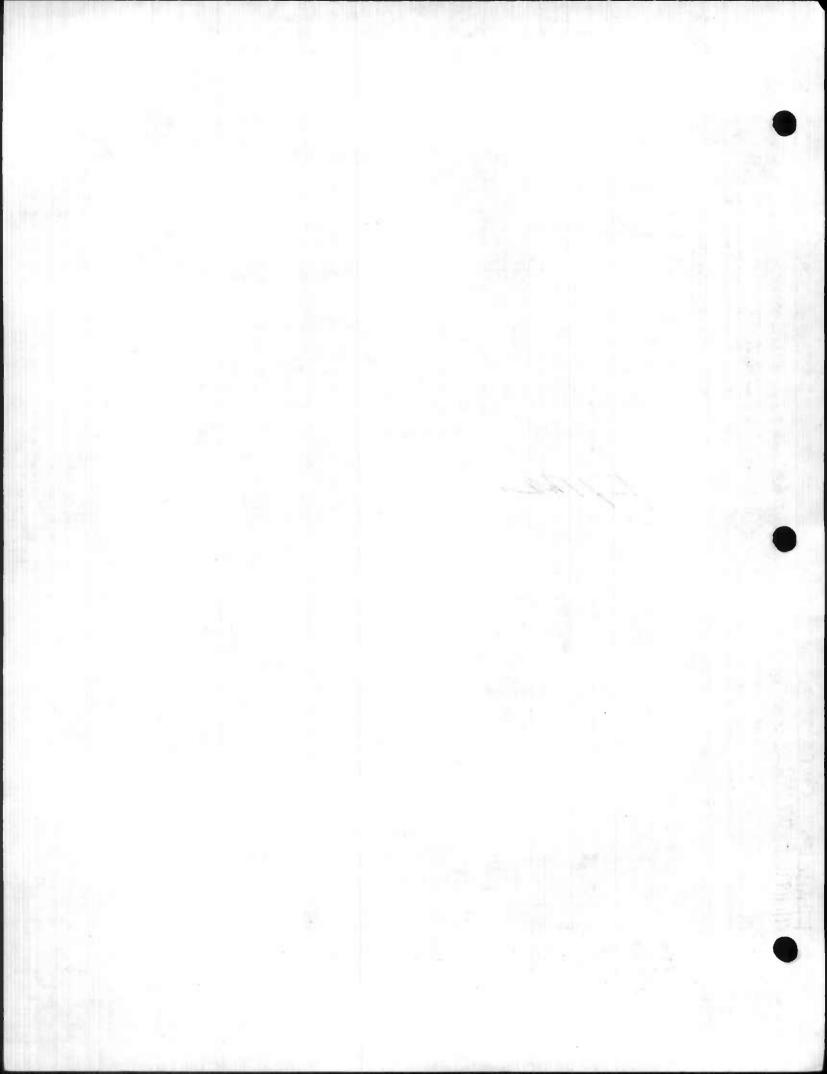
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State of Maryland / Department of Health and Mental Hygiene 99 24 304

					Certific	cate of	Death		Reg. No.		104		
	1. Decede	nt's Name (First, Middle, L	ast)					2. Dete of De Month	eath Day	3. Ti	ma of Death		
ician dical	Fran	nces Pauline	Cooper					July 1			:45 a.		
niner	4a Fecility	Name (If not institution, gi	ive street and number)				4b. City, Town, or	Location of Deat	h 4c. County	of Death			
	Sub	urban Hospita	al				Bethesd	a	Montg	gomery			
1	5. Social S	ecurity Number 6.	Sex 7. Ag	e (In yrs. last	Moi	Inder 1 Yeer			th av. Year)	9. Birthplaca (S Country)	itete or Fore		
		-26-9504	10 M 203 F	94	Yrs.			April 2	2, 1905	Pennsylv	ania		
	Usual Res	Idence of Decedent  10b. County		10c City To	own or Location					10d too	ide City Limi		
5											Yes 2		
Director	Mary.	land Montgon	mery	5117	ver Spr	Lng f. Zip Code			10g. Citizen of V	What Country?	722		
급		08 Homecrest	Dead		"								
Funeral	11. Merital		12. Was Decedent	Ever in II S	13 Wee f	20906		Pracify Vac or N		States - American Indi			
Fun		wer Merried 2 Married	Armed Forces?	-			Hispanic Origin? ( pan, Mexican, Pue	to Rican, etc.)	Blec	k, White, etc.			
by		idowed 4 Divorced	If Yes, Give Yeer or Detes:		1 🗆 Y	es 2 No	Specify:		Specify	white			
8		15. Decedent's 8	ducation	16	Sa. Decedent's	Usual Occu	pation		16b. Kind of Bu	siness/Industry			
Completed	Clamas	(Specify only highest gi			(Give kind of life. DO No	of work done OT use retire	during most of wo	rking					
E	Elemen	tary/Secondery (0-12)	College (1-4or	0+)	Nurses	' Aide			Hospita	al/Home	Care		
Bec	17. Father	's Neme (First, Middle, Las	t)				18. Mother's Na	me (First, Middle	, Maiden Sumam				
ToB	Gre	gor Planin	sek				Fanni	e Grab	lovitz				
-	19a. tnton	mant's Neme/Reletionship	(Type, Print) (down	ah town 1	9b. Mailing Ad	dress (Stree	t and Number or R	ural Route Numb	er, City or Town,	Stete, Zip Code)			
	Con	stance C. Her	ndrickson	gntery	8400 C	ardero	ck Drive	, Bethes	da, Mary	land 20	817		
		od ot Disposition		20b. Plece	of Disposition	(Neme of		Dete		City or Town, St			
		urial 2 ⊠ Cremation 3 I onetion 5 ☐ Other (Spec			sapeake			7/17/99	Beltsvil	lle. Mars	7land		
		ure of Furierel Service Lice		1 01100	-						Zuna		
A DOC		da // K	M				ess of Facility Teral Ser						
	Dan Dan	1. Enter the disease, or cor	mulications that access	M00956			Avenue,				d 209		
Examiner	Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury c.												
Medical	Cause (Disease or Injury that initiated events resulting in death) Lest  Due to (or as a consequence of):												
Physician/	Pert II. Ott	er significant conditions	contributing to death b	ut not resulting	n in the underly	ing cause g	iven in Part I.	23b. Dtd	tobacco use cor	ntribute to the c	euse of de		
thys		Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Dtd tobacco use contribute to the cause of dea				
by F		TROK	E										
									an autopsy ormed?	24b. Were eut avsilable	prior to		
ple										completion of death?	on of cause		
E								10	Yes 2 No	1 □ Yes	20 No		
Be Completed		ase reterred to medical					26. Placa of De	ath (Check only	one)	1			
	25. Was c	ner?	Hospitel:	ent 2∏ERA	Outpatient 30	DOA	hor		idence 6 □Oth	er (Specify)			
o Be	25. Was ca axemir 1  Ye			ry 28t	o. Tima of			1	how injury occurr				
To Be	axemir 1  Ye 27. Mange	os 2D No	28a. Date of Inju	27. Menner of Death 28a. Date of Injury 28b. Tima of third work? 1 Naturel 5 Panding (Month, Day Year) 1 Naturel 5 Panding (Month, Day Year) 1 Naturel 5 MM 1 Yes 2									
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State of Maryland / Department of Health and Mental Hygiene 99 24 305

					(	Certifica	ate of	Death			Reg. No.		24000
	1. Decedent's Na	me (First, Middl	e, Last)							2. Date of De	eath Day	Year	3. Time of Deal
Physician /Medical	Hazel Jo			number)				4b. City. To	wn, or L		23, 19	99 unty of Dea	0210
Examiner	Sunrise 1			noneo, y				E1kt				Cecil	**
Funeral Director	5. Social Security 216-10-20	Number 013	6. Sex 1 ☐ M 2\(\)		yrs. last birth	Month	der 1 Year s Days	If Under		8. Dete of Bir (Month, De August 3			thplace (State or For punity) K Hall, MD
pu a	Usual Residence	of Decedent 10b. County		10	c. City, Town	or Location						-	10d. Inside City Lin
Maryl art sho illad at	Maryland	Kent				Hall							1 (X Yes 2 □
h with the Ma 3a or 28a-f at be notified at Directo	10e. Street and N 5708 Libe		reet.			101.	Zip Code	1661				of What Co	ountry?
72 hours after death with the Marylas natural; or flame 23s or 28s-f show Scal Examiner must be notified at steed by Funeral Director	11. Marital Status 1 Never Ma 3 X Widowed		12. Wes D	ecedent Eve Forces? es 2 No Give or Dates:	r in U,S.		122	Hispanic Ori ben, Mexicar Specify:		ecify Yes or No Rican, etc.)	)- 14.		
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ed within 72 ho righma. wer than "mahum rt. the Medical. Completed	Elementary/Sec		1	e (1-4or 5+)		life. DO NOT	use retire	ed)	cor work		n. 1.1.	- C-1-	. 1 0
Col Marie	12 Feetbar's Name	n /First Middle	( not)		C	ook		19 Mothe	rio Nam	e (First, Middle			ool System
San a	17. Father's Name		Last)									meme)	
To To			hin (Time Drint)		405	Mallion Adde	(С)	1	_	h Minne		ours State	Zin Codel
nd 2 should be file oth and Mental Hy 27 is marked other traumatic event	19a. Informant's Mike Join		anp (rype, rran)							Chester			1620
C 20 CH S	20a. Method of Di				20b. Place of l				α, ι	Date			Town, State
semit. Pages 1 a Seartment of Heam reportant: If Item iny Injury or othe ance.		2 ☐ Cremation 5 ☐ Other (S	3 □Removel fro pecify)	om State	Wesley				- 17	7/26/99	Rock	Hall,	Maryland
Physician /Medical	21. Signature of f	r the disease, or eart feilure. List	complications the	at caused the	death. Do no	Fello	ws, I peer	Road, ing, such as	beir Che cardiac	estertory a	wn, MI		Home, P. 20 Approximate Interval Between Onset and Death
Examiner 5	disease or condit resulting in death	ion )	b		o to (or es a co			- In	fo	uchia			30min
The law requires that the death cartificate be executed ate has been signed by the attending physician and page 2 should be dateched for use as the burial-transit completed by Physician/Medical Examiner		HS T	с		to (or as a co					+			
attendin for usa			d										
es that the death car igned by the attendir be dateched for usa by Physician/A	Part II. Other sign	nificant condition	ons contributing t	o death but n	ot resulting in	the underlyin	g cause g	iven in Part I	1.		tobacco us	/	n to the cause of de
uires the naighed uid be de		V /T	,							24a. Was	en eutopsy	24b.	Were autopsy findin
The lew requires the same requires the page 2 should be Completed by		omou	na								ormed?		completion of cause of death?
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ding Physicien: h. After this certific funeral director, tion: To Be	examiner? 1 Yes 2  27. Manner of Dec	5 Pendir	28a. Do	ate of Injury fonth, Day Ye	28b. Ti	me of jury M	28c. Inju		No	28d. Describe	how injury o	occurred	
is after death as a standing Physics as after death.  a la Director: After this or ed in by the funeral director. To	examiner? 1 Yes 2 27. Manner of De	5 Pendin investi	28a. Do		- At home, fan	jury M	10	Yes 2	No	28f. Location			iural Route Number,
Hospital or Attending Physics     124 hours after death     24 hours after death     124 hours after death     134 hours after this or     aminer? 1 Yes 2, 27. Manner of De 1 Natural 2 Accident 3 Suicide	5 Pendir investi 6 Could determ	ggation not be inned 28e. Pl bu	ace of Injury ilding, etc. (5	- At home, fan Specify) y knowledge, amination and	m, street, fec	1 [ tory, office	Yes 2	nd place,	28f. Location City or To	(Street and I wn, Stete)	Number or F	iural Route Number,	
To the Hospital or Attending Physicien: The iew within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.  Medical Certification: To Be Comp	examiner?  1 Yes 2 7  27. Manner of Be 1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only	5 Pendir investi 6 Could determ  1 Certifyin 2 Medical	ggation not be inned 28e. Pl bu	ace of Injury ilding, etc. (S the best of me besis of exp	- At home, fan Specify) y knowledge, amination and	m, street, fec	1 [ tory, office and at the toon, in my 29c. Licen	Yes 2 ime, date an opinion, dee	nd place,	28f. Location City or To	(Street and I wn, Stete) cause(s) ar date and pi	Vumber or F nd menner a ace, and du	iural Route Number,
To the Hospital or Attending Physic within 24 hours after death. To the Funeral Director: After this or completely filled in by the funeral director.  Medical Certification: To	examiner?  1 Yes 2  27. Manner of De.  1 Natural  2 Accident  3 Suicide  4 Homicide  29a. Certifier (Check only one)	5   Pendir investir 6   Could determ  1   Certifyin 2   Medical	gation not be inned 28e. Pl bu 28	ace of Injury iliding, etc. (5 the best of m e besis of ex anner stated	At home, fan Specify)  y knowledge, amination and	m, street, fec	1 [ tory, office and at the toon, in my 29c. Licen	Yes 2	nd place,	28f. Location City or To	(Street and I wn, Stete) cause(s) ar date and pi	Vumber or F nd menner a ace, and du	iural Route Number, is stated. e to the cause(s)

DHMH 16 Rev 6/95

marking (See) ( 3 Hi)

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3 Time of Courth 1. Decedent'a Name (First, Middle, Last) 2. Date of Death Month Year 12:00 PM JAMES 1999 HENRY JULY 15 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number 4c. County of Death ROAD HESTERTOWN QUAKEL NECK KENT If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Day, Year) Months Days 21651-1260 1 M M 2□ F Yrs. JULY 23, 1920 ENGLAND Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Yes 2 No MD KENT HESTERTOWN 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number HADAWAY DRIVE 21620 ENGLAND 200 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Merried 2 Married ☐ Yes 2 No Yes, Give 1□ Yes 2 No Specify: Specify: WHITE 3 Widowed 4 □ Divorced Yeer or Detes: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MANUFACTURING 1-ITTER FNGINETRING 0 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) COE ICTORIA IALBOT SAMUEL 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/6/20 19e. Informant's Name/Reletionship (Type, Print) QUAKER NECK LESLEY MURRAT ROAD HESTERTOWN MD 20b. Place of Disposition (Name of cometery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriai 2 ★ Cremation 3 ☐ Removal from Stete CHESAPEAKE July 16,198 CHESTER, 4 Donation 5 Other (Specify) CREMATORY FUNERAL SERVICE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MARVIN V. WILLIAMS, JR. 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, of heart failure. List only one cause on each line. CHESTERTOWN, MD Approximete Interval Between Onset and Death NO pulmonary Annest Immediate Ceuse (Final disease or condition resulting in death) cestere Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initieted events Due to (or es a consequence of) that initieted events resulting in death) Last Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. mabiles, Seizure 1 Yes 2 No 3 Probably 4 44 Nown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? Autie Stenaces 1 Yes 2 No 1 Yas 2 No 25. Was case referred to medical 26. Plece of Death (Check only one)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

worle

Director

Funerai

2

Completed

Be

2

7 is marked other than "natural", or itama 23a or 28a-f shor traumatic event, the Medical Exeminer must be incitited at

8

al Hygiene.

permit. Pages 1 end 2 should be file Department of Health and Mental Hy Important: if Item 27 ie marked othe any injury or other traumatic event

the Maryland

death

filed within 72 hours after

altimore, Maryland 21215-0020

Examiner

pue **bunial-tran** be exec physician P.O. Box 68760 the use as attending i by the Records, 8 certificete Division of Vital After this the funeral il or Attending s after death. il Director: Aft

Certification:

Physician/Medical

þ Completed Be 2

State Registrar

edicai

29a. Certifier (Check only one)

examiner 1 Yes 2 No 27. Menner of Death

29b. Signature and title of certifier

31. Dete filed (Month, Day, Year)
JUL 1 6 1999

5 Pending investigation 1 Neturel 2 Accident 3 Sulcide 4 Homicide

6 Could not be determined

28a. Dete of Injury (Month, Day Year) 28b. Time of ront

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Defesidence 6 Other (Specify) 28c. Injury at Work? 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

28d. Describe how Injury occurred

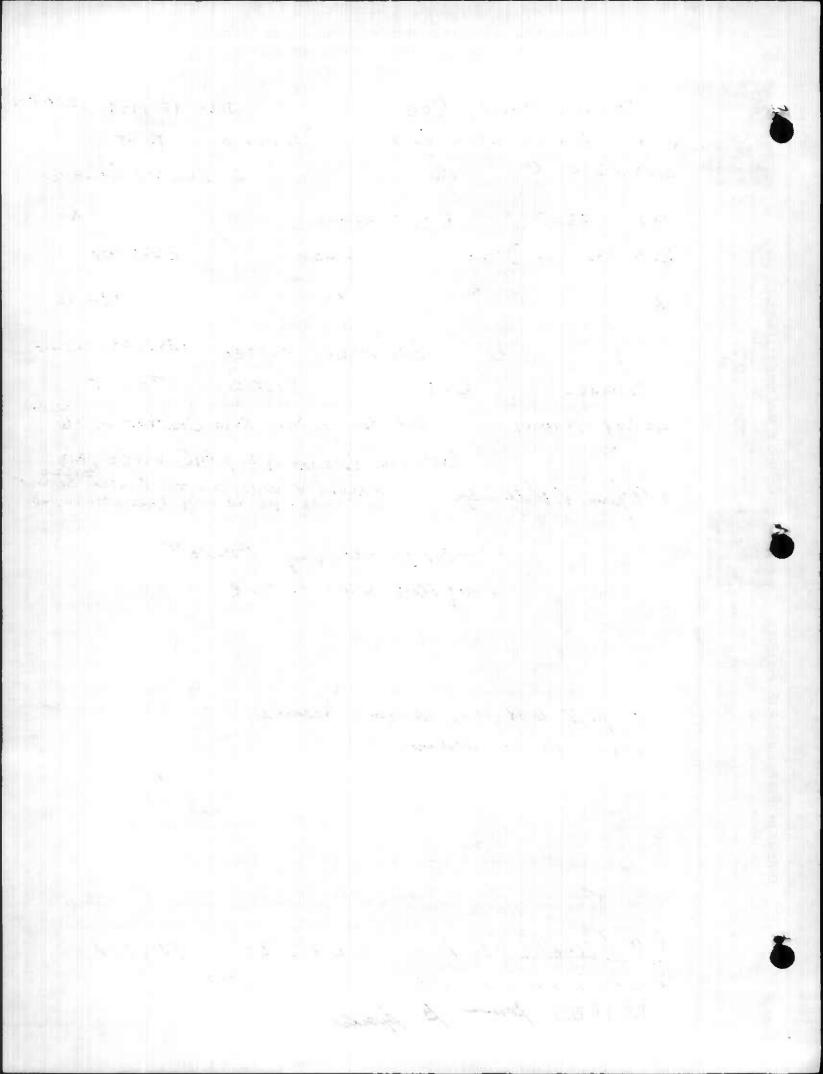
29c. License number

29d. Date signed (Month, Day, Year)

30. No and address of person who completed ceuse of death (Item 23a) (Type, Print) · ARRAMS 21.1 TX.

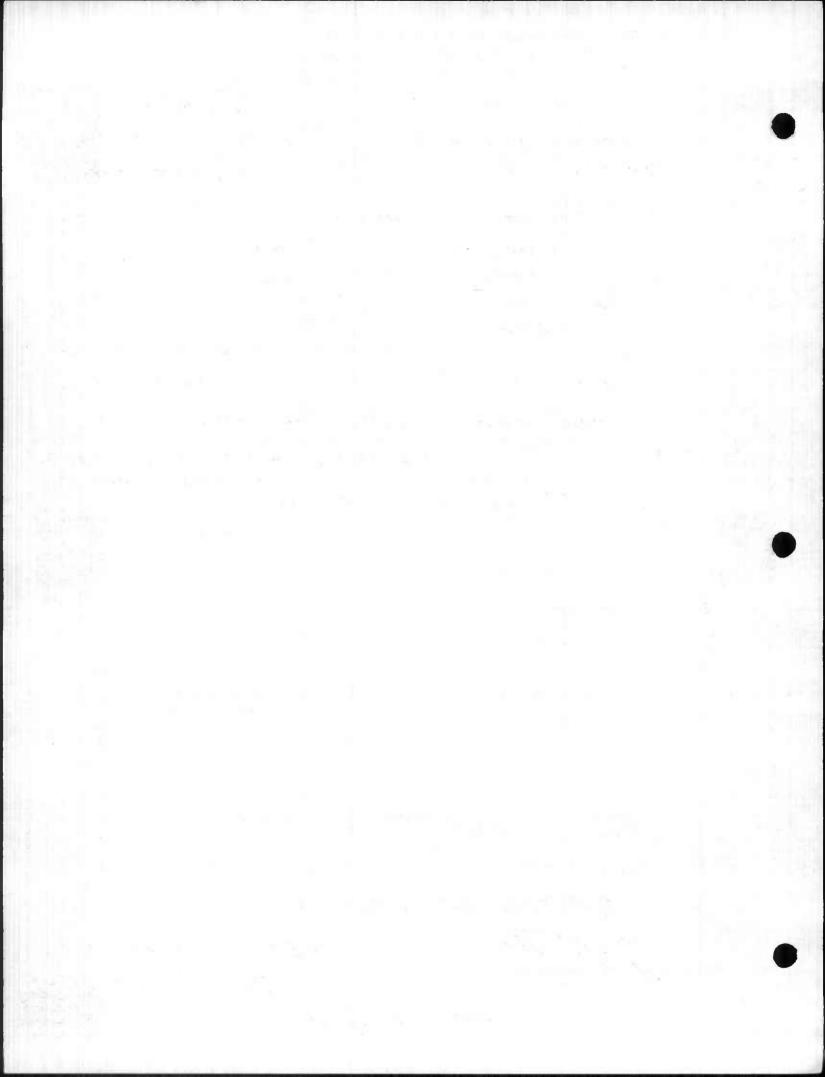
32. Registrar's Signature

To the Hospital o within 24 hours at To the Funeral DI



State of Maryland / Department of Health and Mental Hygiene 99 24307

					Ce	rtificate	of D	eath			Reg. No.			
Physic /Medi		Decedent's Name (First, Middla, L  DONN		AN	CARMINE					2. Date of De Month July	Day	Yaar 999	3. Time of Death 0450	
Exami		4a. Facility Nama (If not institution, g Dorchester			ital			Ca	mbri	ocation of Deat Ldge		of Death Cches	ter	
Funeral Director		5. Social Security Number 218–48–6743  Usual Rasidance of Dacedant	Sex 1□M 2 <del>2</del> F	7. Age (In ) 51	rs. last birthday Yrs.		ays	Hours	24 Hrs. Min.	8. Data of Bir (Month, De Feb. 1	7 1948	9. Birth Cou Mar	place (State or Foreign ntry) yland	
anyland show		10a. Stata 10b. County	1	10c.	City, Town or L								10d. insida City Limits	
the Mar 23a-f st notified	Director	MD Dorc	hester		Ca	mbridge					40- 00		17 Yas 2□ No	
23a or			Virgin	ia Ave		10f. Zip Co	O.e.	21	613	U.S.A.			ntry7	
of 2 should be filed within 72 hours after dear th and Mental Hygiene. 7 is marked other than "natural", or itsens it treumwite event, the Medical Examiner ms	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed	12. Was Dec Armed Fo 1Yes If Yes, Gi Yaar or D	orcas? 2 <del>12</del> No ∨a	n U,S. 13.	Was Decedent if Yas, specify 1 ☐ Yas 2 ☑	Cuban,	panic Orig , Mexican Specify:	gin? (Sp i, Puarto	ecify Yas or No Rican, atc.)		can Indian, atc. white		
be filed within 72 ho ntal Hygiene. Ind other than "natur event, the Medical	Completed	15. Decedant's I (Specify only highast g Elemantary/Secondary (0-12) 1 2	Education rade complated) Collega (		(Give	dent's Usual O kind of work d DO NOT use ri	ona du atired)	ring most		eng perator	16b. KInd of B			
2 should be filed and Mental Hygin is marked other numetic event, it	To Be C	17. Fathar's Name (First, Middla, Las William		nell	Todd		1		etti	ne (First, Middle, Maiden Sumama)				
		19a. Informant's Name/Ralationship Donna Carpenter		ter						al Route Numb 1D 2167	oer, City or Town, Stata, Zip Code)			
nit. Pages 1 and artment of Health ortsett: if lien 27 Injury or other it		20a. Mathod of Disposition  172 Burlai 2 ☐ Cremation 3  4 ☐ Donatlon 5 ☐ Othar (Special Control Contr		State		matory or other	place)		ry	Data 7-22-99	20c. Location East Ne		own, State	
permit. Pages 1 ar Department of Hea Important: If Hem 2 any Injury or other salse.		21. Signature of Funaral Sarvice Licensee  22. Nama and Addrass of Facility Thomas Funeral HOme PA  700 Locust St. Cambridge MD 21613												
Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or complications that caused the teath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Finel disease or condition resulting in death)  Due to (or as a consequence of):												
ficate be executed physician and as the bunal-transit	Examiner	Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying	b. — Due to (or as a consequence of):											
certificate be nding physicie use as the bu	n/Medical	Cause (Disease or Injury that initiated evants rasulting in death) Last  Due to (or as a consequence of):												
requires that the death certificate be executed eason signed by the ettending physician and hould be detached for use as the burial-transitional and the state of	y Physician										23b. Did tobacco use contribute to the cause of the cause			
2 s 2	Completed by									24a. Was	ere autopsy findings allable prior to implation of cause death?			
		25. Was casa rafarred to medical	1							10		1	Yas ZBAO	
ysician: ils certific	To Be	axaminar?	Hospital:	Inpatient 2	□ ER/Outpatie	nt 3□ DOA	Other:			th <i>(Check only o</i> ome 5 ☐ Resi	one) dence 6 □Oti	nar (Speci	(y)	
Attending Physician: r death. ector: After this certific by the funeral director,		27. Mannar of Death  1 ☐ Matural 5 ☐ Panding 2 ☐ Accident Investigation		of Injury th, Day Year	28b. Tima o Injury	f 28c.	injury a Work? 1 □ Ya	at as 2 □ l	No	28d. Dascribe	how injury occu	rred		
Hospital or Attend 24 hours after deat Funeral Director: etely filled in by the	Certification:	3 ☐ Sulcida 6 ☐ Could not 4 ☐ Homicida datarmine	A 28a. Place	of Injury - Ang, etc. (Spe	t homa, farm, st ecify)	reet, factory, of	ica			28f. Location ( City or To	Streat and Num wn, Stete)	ber or Run	al Routa Number,	
To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check only one) Gertifying P	miner: On the b	best of my less of exam	nowledga, daat Ination and/or In	n occurred at the vestigetion, in r	e time, ny opin	, data end nion, deat	d place, th occur	and dua to tha red at tha tima,	causa(s) and m data and piece,	anner as s	stated. o tha cause(s)	
To the within 2 To the comple	M	29b. Signatura and titla of certifier	Ellu	ar		29c. Lie	2/	10	88	3	29d. Date signe	1-1	900	
Sta	te	30. Name and address of person who 31. Data filed (Month, Day, Yaar)	Adder	a of death (I	tam 23a) (Type,	Print)	1/50	us	H	07/00	k 1	nel	21643	
Registr		JUL 21	1999	Gener	~ 6	do	rely	/						



Please Type or Print in Black Indeible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 07.14.1999 4:50PM ETHEL GOLDSTEIN DWORETZKY 4b. City, Town, or Location of Deeth 4e Facility Name (If not institution, give street end number) 4c. County of Death MONTGOMERY HEBREW HOME OF GREATER WASHINGTON ROCKVILLE If Under 1 Year If Under 24 Hrs. Months Deys Hours Min. 8. Date of Birth (Month, Dey, Year) AUG. 4, 1 5 Social Security Number 7. Age (In vrs. lest birthdey) 9. Birthplece (Stete or Foreign Sex 1 M 2 F Months Yrs. FLORIDA 95 263.82.4086 Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Yes 2 No ROCKVILLE MARYLAND MONTGOMERY 10e. Street end Number 10f. Zin Code 10g. Citizen of Whet Country? 20852 usa 6121 MONTROSE ROAD 12. Wes Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14 Bace - American Indian Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Yes 2 ☐No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Spoondary (0-12) OWN HOME HOMEMAKER 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) IDA MORRIS MICHAEL GOLDSTEIN 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Reletionship (Type, Print) 10705 GLOXINIA DRIVE, ROCKVILLE, MARYLAND ADELE SAMLER/NIECE 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) KING DAVID MEMORIAL GDNS 7.18.99 FALLS CHURCH, VIRGINIA 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 21. Signeture of Funeral Service Licenses 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Deeth Immediate Cause (Finel TSCHEMIC CARDIDMYOPATHY diseese or condition resulting in deeth) Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or as a consequence of). Due to (or as e consequence of) Pert fl. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No PNEUMONIA BOTH LOWER LOBE 3 Probably 4 Unknown ASPIRATION 24b. Were autopsy findings available prior to 24a. Wes en eutopsy performed? completion of cause of deeth? 2 No 1 Yes 2 No 1 ☐ Yes 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28d. Describe how Injury occurred

**Physician** /Medical Examiner physician at s the burial-t 88 ISB

Examiner

Physician/Medical

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Completed

Be

Certification: To

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show

permit. Pegas 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiena. Important: if item 27 is marked other than "natural", or items 23s or any injury or other traumatic evant, the Moderal Exercitor chair be in public.

Directo

Funeral

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Completed

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The law requires that the death cartificate be executed Division of Vital Records, P.O. Box 68760. signed by t should I cartificeta hes t af or Attending Physician: T s aftar daath. if Director: After this cardificet od in by the funeral director, p To the Hospital or within 24 hours aft To the Funeral Di completaly filled in

9

State

Registrar

25. Was cese referred to medical exeminer? \_ / 1 Yes 2 No 27. Marmer of Death 28e. Date of Injury (Month, Dev Year) 28c. Injury et Work? Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Plece of fnjury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier (Check only one)

29b. Signature end the of partitie

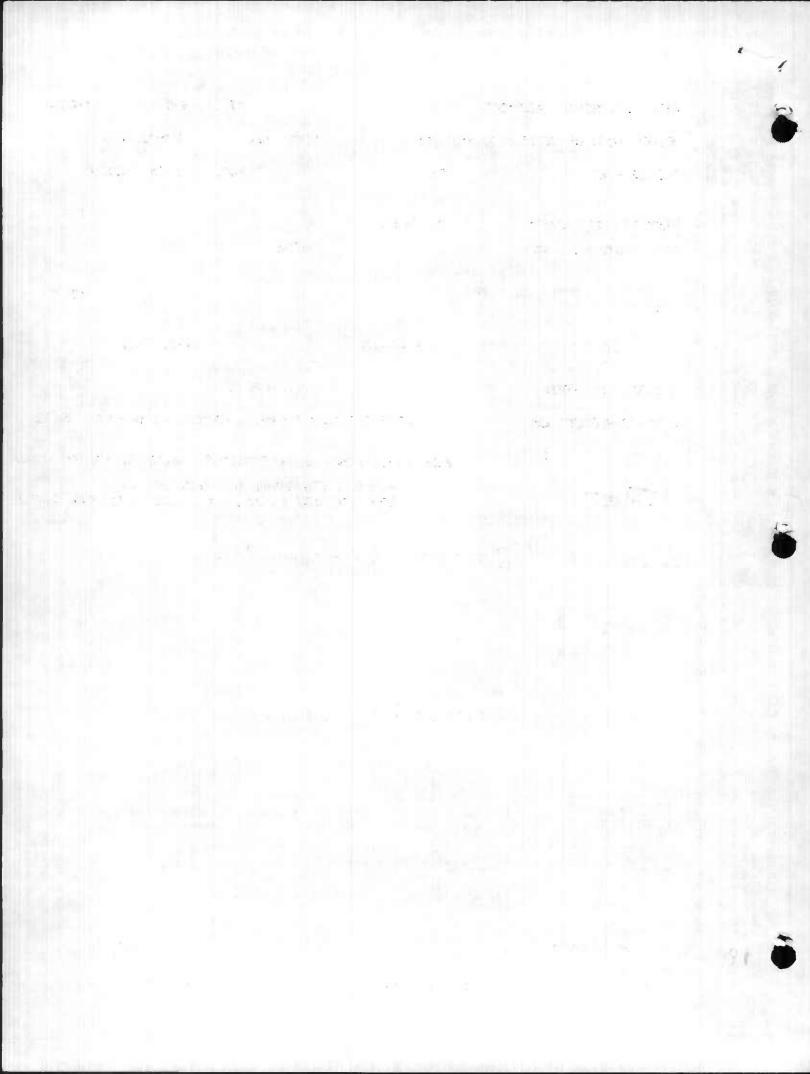
29c. License number 18084 29d. Dale signed (Month, Dey, Year)

30. Name end eddress of person who completed ceuse of death (Item 23a) (Type, Print)

MONTROSE RD ROCKVILLE, MD 20852 6121

31. Dete filed (Month, Dey, Year) 2 1 1999

32. Registrer's Signature renewa



State of Maryland / Depa

artment of Health and Mo	ental Hygiene	9	9	2	1	3	n	0
tificate of Death	Reg. No.			Free			U	1

	1000	1. Decedant'a Nema (First, Middla, Last)								2. Date of Month		Day	Yaar	3. Tima of D
Physician /Medical	Mar	ian					Det	npse		July		1999	15 "	1:19/
Examiner		ame (If not institut							4b. City, Town,		Jeath .			
	5. Social Sec	kville N	6. Sex			last birthday	) If Unde	r 1 Yaer	Rockvil		f Rinth		y of Deeth  gomery  9. Birthplaca (Stata or Country)  10d. Inside Ci 1 Yes  Whet Country?  A ce - American Indian, eck, White, etc.  Thy: White  Businass/Industry  an Institut hitects  me)  SCO, CA 9  - City or Town, State  Church,  Sons  D. C.  Approximat Intarval Bat Onset and Interval Bat Onset	a (Stata or i
Funeral Director	165-1	.8-6549		M 284 F	81	Yrs.	Months	Days		in. 8. Deta c (Mont) Oct.	. Day, Ye	917	Country	PA
28a-f show notified at rector	10a. Stata	10b. Coun	tgon	nery	10c. Ci	ty, Town or L		Roc	kville				10d.	Inside City
or 28a-f sho be notified at Director	10e. Street a	nd Number					10f. Zip	Code			10g. Citizan of Whet Country?			
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Mental tygiene. Irked other than "natural", or items 23s or 23s 1 state event, the Medical Exeminer must be notified. To Be Completed by Funeral Director	11. Marital St 1 □ Neva 3 🙀 Wido	r Merried 2 ☐ Ma wed 4 ☐ Divorca	arried	2. Was Deced Armed Ford 1 Yas 2 If Yas, Give Year or Dat	as? No		If Yas, specify Cuban, Maxican, Puerto Rican, atc.)  Bleck, White, etc.  1□ Yas 2點 No Specify: Specify: White							
th and Mental Hygiene. 7 is marked other than "natural", or traumatic event, the Medical Example To Be Completed by F	Elemantary	15. Decedo (Specify only high y/Secondary (0-12	hast grada	College (1-4	4or 5+)	16a. Dece (Give lifa.	edant's Usu a kind of wo DO NOT u	al Occup ork dona sa ratired	a during most of working  red) Executive Ame			merica	n Inst	itute
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ed of or several Be	Will.	iam Mor		Fav						lyn Ru		oen ogman	16)	
T To		nt's Name/Relation				19h Mail	ling Addras	s (Street				ity or Town.	State. Zin Co	ode)
trau		iam M.			Son				t. #80					
Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Managace.  To Be Compi	1 □ Buria 4 □ Dona	of Disposition al 2 文 Cramatior ation 5 Other of Funeral Service	(Specify)				1 Cro	emat	ss of Facility	Joseph	99Fa	alls wler	Churc's Son	h, V
05 = 0	Thomas E. Hombake 5130 WI Ave. NW Washington, D. C. 2  3a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Between the control of the co													. 2
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ysician and ne burial-transit ical Examine	Sequentially if eny, leadin cause. Enter Causa (Disas that initiated	list conditions, g to immadieta r Underlying asa or Injury avants	<b>\</b> .		Dua to (	or as a conse	equanca of):							
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for use a		list conditions, g to immadista r Underlying asa or Injury avants leath) Last			Dua to (c	or as a conse	equanca of):		van in Part I.	23b.	Did toba	acco use co	ntribute to th	ne cause of
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within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a Medical Certification: To Be Completed by Physician/M	25. Was case examiner 1 Yas 27. Mannar or 1 Natur 2 Accid 4 Hom 29e. Cartiflar (Check ore) 29b. Signatur	a rafarred to medic  2 X No  f Death ral 5 Pendant invatida 6 Coul icida dete	cal Huding stigation id not be rminad ei Examin	ospital: 1 In In In In In In In In In In In In In	Dua to (continue)  Dua to (conti	DER/Outpatie 28b. Tima Injury coma, ferm, s fy)	equance of):  undarlying of  ent 3 Do  of  M  undarlying of  the occurred invastigation  29	causa given a ca	26. Place of har: 4X Nursin yat k? Yes 2 No	24e.  Death (Check of g Homa 5 1 28d. Dasc City of aca, and dua to courred at the second seco	Was en a performe 1 Yes only one) Rasidano ribe how ion (Street Town, 5 or tha causima, date	2 X No  autopsy d?  2 X No  ca 6 □Oth Injury occurr  et and Numb State)  sa(s) and ma e and placa, i. Deta signe	3 Probat  24b. Wara avelle composed of der  1 Year (Specify)  anner (Specify)  anner es state and dua to the difference of Month, Da	ed. a cause(s)

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State of Maryland / Department of Health and Mental Hygiene 9 2 4

Certificate of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Death 1999 Month **Physician** James Edward Davis. July 17, B:51 p.m. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Futurecare Chesapeake Arnold Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1X M 2□ F Months Days Hours Min 212-66-1501 Yrs. 45 Director Jan 19, 1954 Japan Usual Residence of Decedent the Manylend 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumstic event, the Medical Exp. in er must be notified at MD 1 ☐ Yes 212 No Anne Arundel Director Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1161 Ramblewood Drive 21401 USA death Funeral 12. Wes Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Meritel Stetus Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after or Department of Health and Mentel Hygiene. Important: if item 27 Ie marked other than "natural", or iter 1 Yes 2 No if Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) High School Elementary/Secondary (0-12) College (1-4or 5+) Teacher Educator 18. Mother's Name (First, Middle, Maiden Surname) Betsy Johnson 17. Fether's Name (First, Middle, Last) Be James E. Davis, Sr. Lo 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) 1161 Ramblewood Drive, Annapolis, MD Mary Davis / wife 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State July21 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State any Injury or Dorchester Mem. Park Cambridge, MD 4 Donation 5 Nother (Specify) entominment 1999 22. Name and Address of Fecility 21. Signature of Fu arat Sarvice Licen Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146

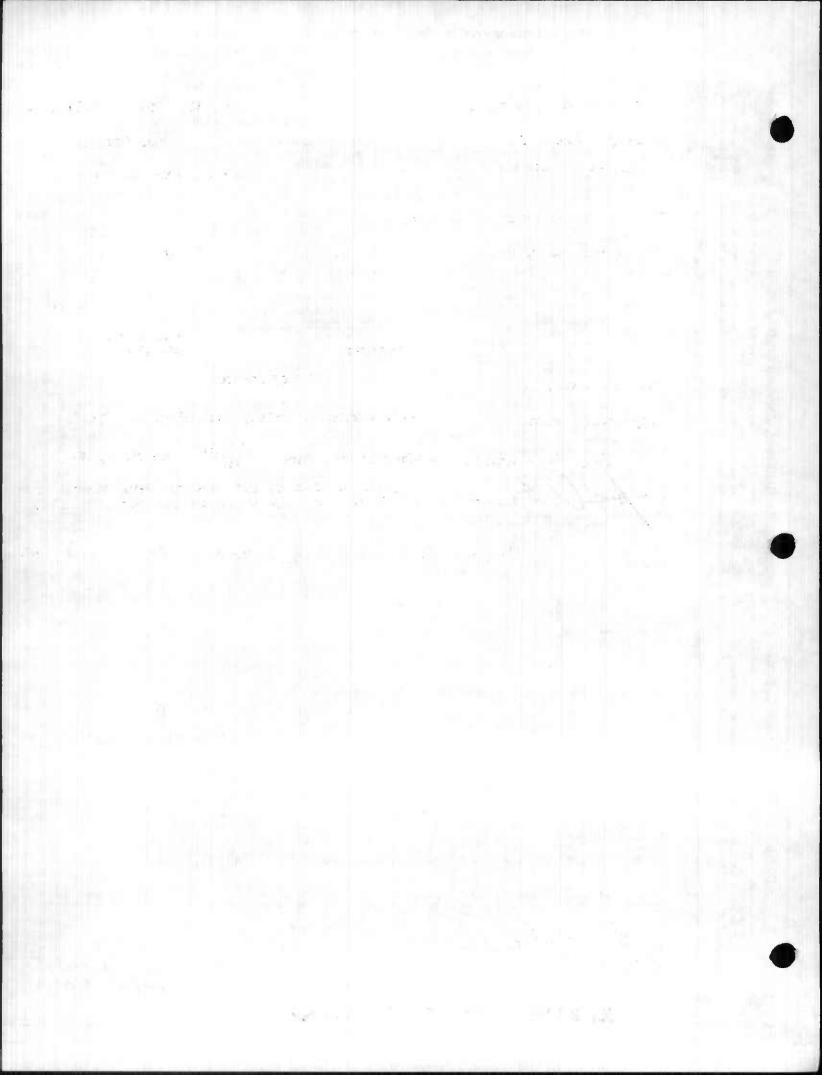
Inter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest,

Approximate

Approximate Approximate Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) HOENO CAMINOMA OF UNKNOWN OROW Examiner Due to (or es e consequence of) Examiner physician and s the burial-trans Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury that Initieted events resulting in death) Last Due to (or es e consequence of): Box 68760, that the death certificate be Physician/Medical Due to (or es a consequence of): 98 980 23b. Did tobacco use contributa to the causa of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. signed by t d be detect 1 Yes & No 3 Probably 4 Unknown p 24b. Were autopsy findings available prior to 24a. Was en eutopsy performed? Completed completion of cause of deeth? page 2 has 20-No 1 Yes 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Piece of Death (Check only one) Hospital: Other: 4 Nursing Home & Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 28a. Date of Injury (Month, Day Year) 129Natural 5 Pending 24 hours after deeth.

Funeral Director: Af 1 Yes 2 No investigetion 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, State) Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 - Homicide edical 29a. Certifier 24 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) and menner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the To the 29d. Date/signed (Month, Day, Year) 29c. License number 29b. Signature and 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Dete filed (Month, Dey, Year) 32. Registrar's Signature State JUL 2 0 1999 Registrar

DHMH 16 Rev 6/95



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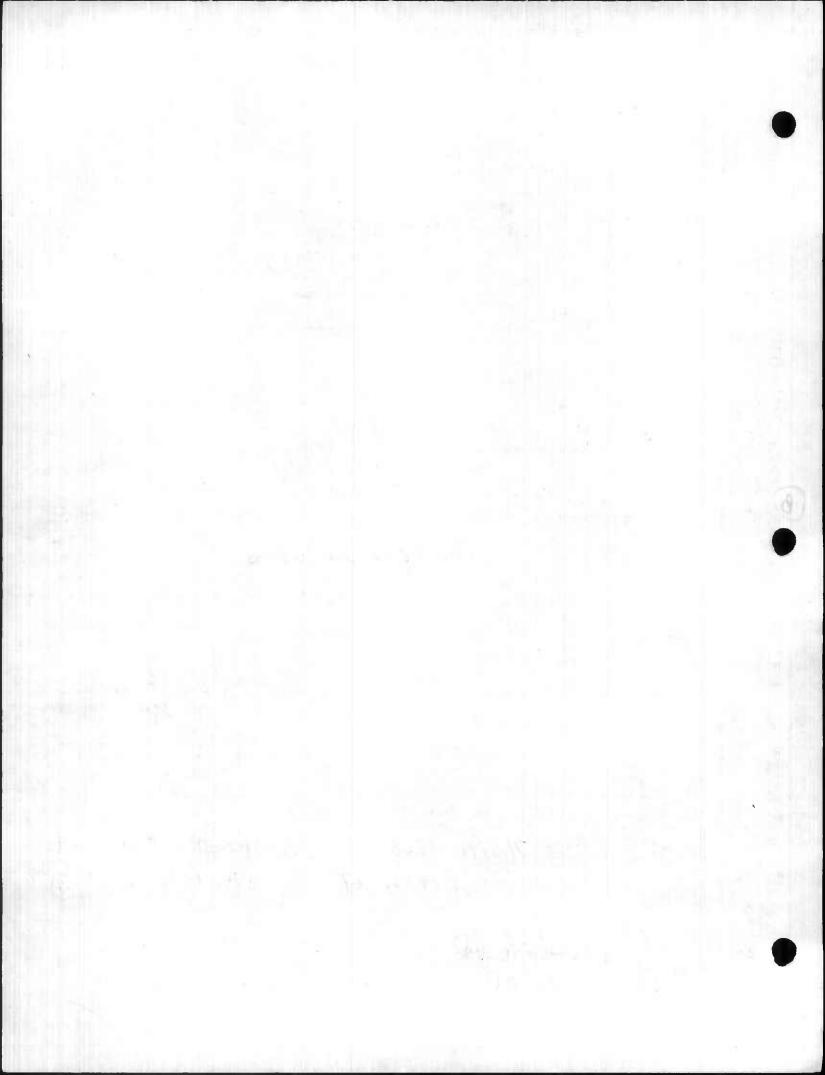
State of Maryland / Department of Health and Mental Hygiene Q

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Baltimore, Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours effer death with the	Separation of near and white attending physician and Separation of important if Item 27 is marked other than "natural", or Items 23s or 28s.
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Il Records, P.O. Box 68760,	lew requires that the death certificate be executed	sate has been signed by the attending physician and

				Cer	tificate	of I	Death			Reg. No.	1 6	4011				
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	JOSHUA TYLER I	FFN							Month JULY	Day 15, 199	Year 9	1:04P.M.				
	4a Facility Name (If not institution		mber)			14	b. City, To	wn, or Lo	ocation of Death							
To Be Completed by Physician/Medical Examiner  To Be Completed by Physician/Medical Examiner  To Be Completed by Physician/Medical Examiner  To Be Completed by Physician/Medical Examiner	WASHINGTON ADVE	NTIST HOS	PITAL				TAKON	IA PA	ARK	MONTO	OMERY	Y				
	5. Social Security Number	6. Sex	7. Age (In yrs. last	birthday)	If Under 1		If Under		8 Date of Birt	h						
	216-39-9681	1€ M 2□ F	5	Yrs.	Months	Deys	Hours	Min.	(Month, De	7. Year)		lace (Stete or Foreign try)				
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rec	10e. Street and Number	omery		TVEL	10f. Zip C					10g. Citizen of What Country?						
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pie	(Specify only high Elementary/Secondary (0-12)	est grade completed) College (	1-40(51)	life. L	kind of work DO NOT use	retired	during mos 1)	t of work	ing							
E	1	College (		Stud	ent					N/A						
	17. Father's Neme (First, Middle	, Last)			-		18. Mothe	er's Nemo	e (First, Middle,	Maiden Sumer	10)					
3	Jeremy F. Deer						ц	len	J. Shar	12						
-	19e. Informant's Neme/Relation		1	19b. Meilir	ng Address (	Street				er, City or Town,	State, Zip	Code)				
	Jeremy F. Deer	(Fo	ther) 8	500	Tahona	D.	1370	C+1-	zor Car	ing Mary	land	20002				
	20a. Method of Disposition	L (ra	20b. Place	e of Dispo	sition (Neme	of		OTT/	Date							
	1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State cemetery, cremetory or other place)															
	4 Donetion 5 Other (Specify)  Gate of Heaven Cemetery 7/19/99 Silver Spring, MD  21. Signeture of Funerel Service Licensee 2 / ()  22. Name and Address of Facility															
	22. Name end Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901															
	Weller	of Dy	d	500	0 Univ	ers	ity I	31vd	.,W.,Si	lver Spr	ing,					
	23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that of t only one cause on e	eaused the death. Death line.	Do not ente	er the mode	of dyin	g, such es	cardiac	or respiretory er	rest,		Approximete Interval Between				
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	Immediate Cause (Final disease or condition		11/0/	+01	e )	1	J'M	1	1							
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0	1 □ Natural 5 □ Pendi	- /	th, Day Year)	b. Time of Injury		Wor		No	Po da L	of Ho	. 41.	c.t				
Car	3 Suicide 6 Could	not be	199 /	WS	М		Yes 2		140001	100 91V	MAN	James				
Certification:	4 Hornicide deter	nined 200. T1008	of Injury - At home ng, etc. (Sugary)	, term, str	eet, tectory,	office			28t. Location (S	Street end Numb State)	er or Ruh	Houte Number				
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edical	(Check only 2 Medical	ng Physician: To the Examiner: On the ba														
8	one) / A	and man	ner steted.													
Σ	E 29b. Signature and title of certifier 29c. License number									29d. Dete signe	a (Month,	Dey, Year)				
	1/ Als	torfe	Me			0.	C.M.E	E.		JULY 16	, 1999					
30 Name and address of person who completed cause of death (Item 23a) (Type, Print)																
	J. AKON (	DUG, MI	)	1	lll Pe	nn	Stree	et, E	Baltimor	e, Mary	land	21201				
te	31. Dete filed (Month, Day, Year	32. 8	egistrer's Signeture							_						
ar	run 2 1	1999	neva	19	don	1	/									

DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Physician Month July 20, Henry A. Drak 1999 6:45am /Medical 4a Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Iver Spring Silver Montgomery If Under 1 Year 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months 1₽M 2□ F Yrs. 78 Sept. 13, 1920 Pennsylvania Director 175-16-1133 Usual Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow 1 Yes 2 No must be notified Directo Maryland Montgomery Silver Spring 28a-f 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or 1307 Ruppert Road 20903 USA Funeral 14. Rece - American Indien, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status ather 1 ⊠ Yes 2 No If Yes, Give WWII Year or Detes: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White ğ 3 ☐ Widowed 4 ₺ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Hygiene. ther then Elementery/Secondery (0-12) College (1-4or 5+) Railway Clerk Conrail permit. Pages 1 and 2 should be lile Department of Health and Mental Hy Important: If Nem 27 is marked oths any Injury or other traumatic event. 17 Father's Neme (First Middle Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Be John Draczkiewicz Stephanie Ganczak 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Drak/ Daughter 1307 Ruppert Road, Silver Spring, MD 20903 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stela July 24 1999 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Calvary Cemetery Pittsburgh, PA 22. Name and Address of Fecility 21 Signature Th Funeral Service Licensee Francis J. Collins Funeral Home, Inc. 500 University Blvd. W., Silver Spring, MD 209 attions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, linerval Between Conset and Death MD 20901 23a. Pert1. Enter the disease, or complished, or heart feilure. List only or **Physician** /Medical Immediate Cause (Final diseese or condition resulting in death) Pneumonia 5days Examiner Due to (or as a consequence of) Examiner physician and the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Box 68760. certificate be Physician/Medical that initieted events resulting in death) Last Due to (or as e consequence of) 80 usa Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. the 1 Yas 2 No 3 Probably 4 Unknown Parkinson's disease P 24b. Were autopsy lindings aveilable prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 s has 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Division of Vital 8 25. Was case referred to medical 26. Place of Death (Check only one) To. Hospitel: 1 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After I 5 Pending investigation TX Netural 1 TYes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, larm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) end manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and menner steted. edical 29e. Certifier (Check only one) 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifie, D09834 July 20, 1999 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barry N. Rosenbaum 3720 Farragut Ave., Kensington, MD 20895

**DHMH 16 Rev 6/95** 

State

Registrar

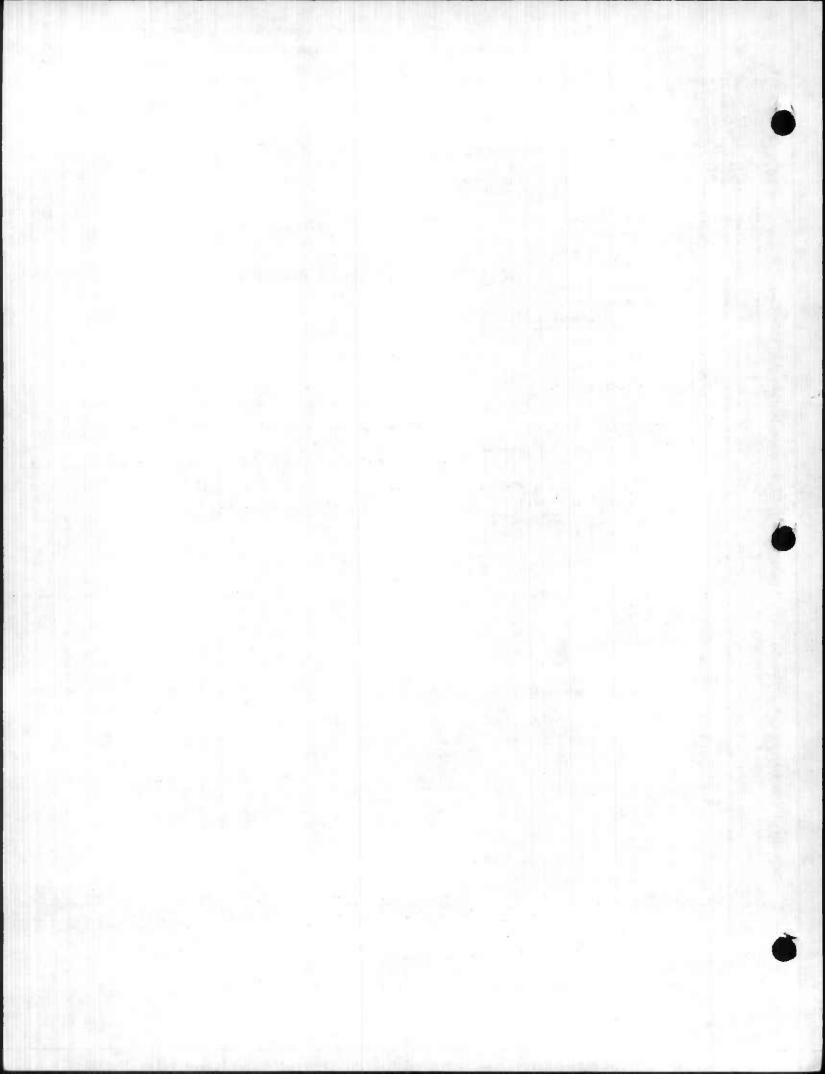
31. Date filed (Month, Dey, Year)

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2 1 1999

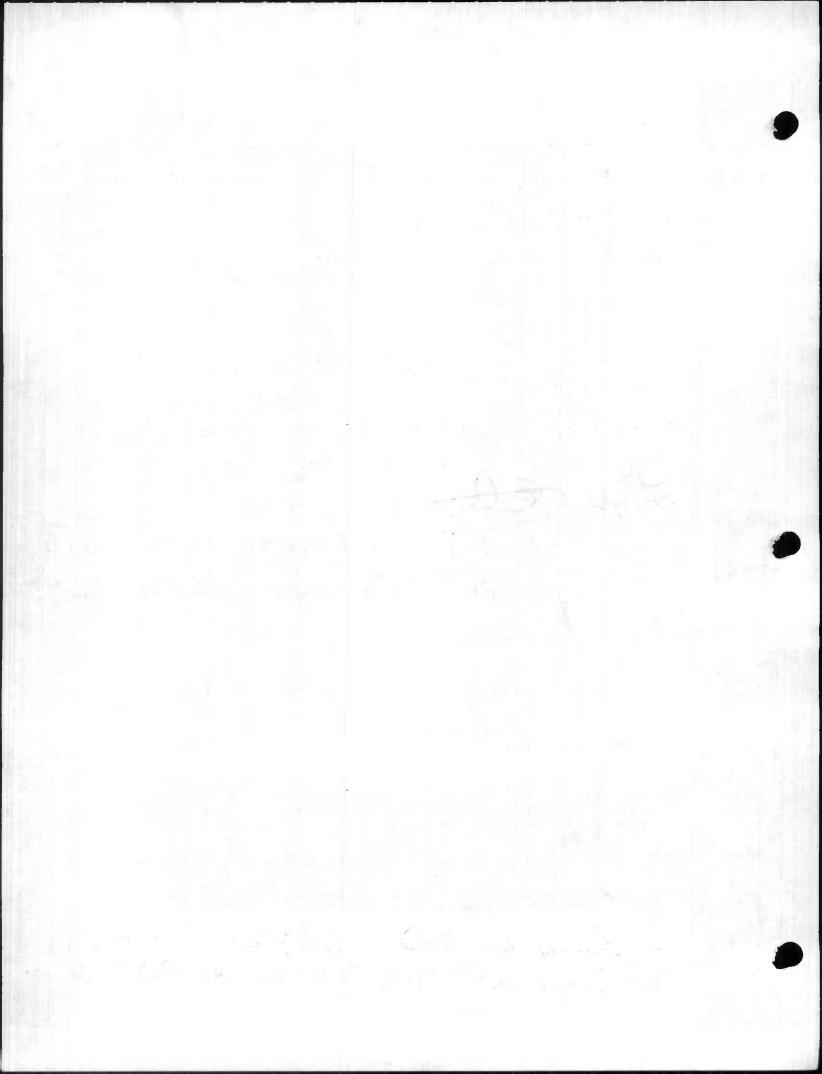
32. Registrer's Signeture

Epera



State of Maryland / Department of Health and Mental Hygiene O O

			Certificate of Death		Reg. No.	24313
П	Dhusia		Decedent's Neme (First, Middle, Last)	2. Dete of De	eth	3. Time of Death
	Physic /Medi		Essie J. Davis	July		3:19 am
	Examir		4e. Facility Name (If not institution, give street end number)  4b. City, Town, or L	Location of Death	4c. County of	Deeth
	No.	Ш	14006 Baden Westwood Rd Brandyw	ine	Prince	e Georges
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)   ft Under 1 Yaar   ft Under 24 Hrs.  212-38-4122   1   M 2   2   F   0.2   Yrs.   Months   Days   Hours   T Min.	8. Deta of Bird (Month, De	h 0	Distriction (Otalian Francis)
	Director		Usuel Residence of Decedent	uary 4	, 1906Soi	country) Carolina
	Mend Mend		10a. State 10b. County 10c. City, Town or Location			10d. inside City Limits
	Man H	tor	Maryland Prince Georges Brandywine			X⊠Yes 2□No
	or 28	irec	10e. Street end Number 10f. Zip Code		10g. Citizen of Wha	at Country?
	th wil	alD	14006 Baden Westwood RD 20613		U.S.	Α
	e ame	Funeral Director	11. Merital Status  12. Wes Decedent Ever in U,S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Sr. Mexicen, Puarte	pecify Yes or No	14. Rece -	Americen Indian, White, etc.
20	72 hours after deeth with the Manylend natural, or Itams 23a or 28a-f show ores Example must be notified at	F	1 Nevar Married 2 Married 1 Yas 2 No	o moan, etc.,	Specify:	vanite, etc.
21215-0020	72 hours "natural",	d by	3Xº Widowed 4 □ Divorced Year or Dates:			Black
15	within 72 ho iene. than "natur The Medical	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired) (If DO NOT use retired)	king	16b. Kind of Busin	ess/Industry
212	filed within Hygiene.		Elementery/Secondery (0-12) College (1-4or 5+)  12 Cosmetologist		Coomaka	1-
	be filed tal Hygie d other event, tr	BeC	335	ne (First, Middle,	Cosmeto Meiden Surneme)	Toda
Maryland	U 2 4 0	ToB	Unknown	nown		
lan	d 2 should th end Men 7 is marks traumatic		19e. Informent's Neme/Relationship (Type, Print)  19b. Melling Address (Street end Number or Rus		er, City or Town, Ste	ate, Zip Code)
	27 mg		Mckinley Bright- Son 14006 Baden Westwood Rd,	Brandy	vine Mar	vland 20613
Baltimore,	of the		20e. Method of Disposition  20b. Plece of Disposition (Name of cemetery, cremetory or other plece)	Date	20c. Location - Cit	y or Town, Stete
Ë	Pages ment of i ant: If its ury or o		4 Donetion 5 Other (Specify) St. Thomas Ch Cem. 7/30	0/99	Brandywi	ne MD
Sall	permit. Pag Department Important: I any injury o		21. Squature of Survice Licensee 22. Name and Address of Facility			
ш	20549		Adams Funoral Hor	mo D 7	7	20608
-			Adams Fune al Hor 23a. Pert 1. Enter the disease, or complications that causad the death. Do not enter the mode of dying, such as cerdiac shock, or hyart failure. List only one cause on each line.	or respiratory ar	Aquasc	Approximata
1	Physician					Unset end Deeth
7	/Medical Examiner		Immediate Cause (Final disease or condition resulting in deeth)  e  ORONARY  ARTER			
		er	Due to (or es e consequence ot):  Due to (or es e consequence ot):	man	2100	71.
	betr Insit	Examiner	CEREISKU VAJCUURR	17126	SASC.	. / 177
ó	death certificate be executed e ettending physician end of for use as the bunal-transit	Еха	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury c.			
68760,	ysicie	Medical	Cause (Diseese or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of):			
	ng ph	Med	resulting in deeth) cast			
Вох	eath cer ettendir for use	Physician/	d			i
		sici	Part il. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert i.	23b. Did t	obacco use contri	buta to the cause of death?
P.0	requires that the de- een signed by the e hould be deteched f	Phy	EDEMA	101	/es 2□ No 3	□ Probably 4 □ Unknown
	igne bed	by	V- V- V- V- V- V- V- V- V- V- V- V- V- V			
Vital Records,	v requir been s should	Completed	CARDIAC ARRHWITHMIA	24a. Was perfor	an eutopsy 2 med? 2	4b. Wera autopsy findings aveilable prior to
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<u>e</u>	E 88			1 🗆 Y	es 2×No	1 Yes 2 No
Z.	Physician: The this certificate ral director, page	Be	25. Wes cese referred to medicel axeminer?  Hospitel: Other: Other:	th (Check only o	ne)	
ō	this aidi	. To	1 Inpatient 2 ER/Outpetient 3 IDOA 4 Nursing Ho		ence 8 Other (	Specify)
on	ding h. After fune	tlon	1 Netural 5 Pending (Month, Dey Year) Injury Work?	200. Describe n	ow injury occurred	
Division	i or Attending after death. I Director: After d in by the fune	Certification:	3 Suicide 6 Could not be	28f. Location (S	treet and Number o	or Rural Route Number.
ă	afte i Dir	ert	4 Homicide determined building, etc. (Specify)	City or Tow		
	papita houn mera ly fille		29e. Certifier Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece,	and due to the d	euse(s) end menne	er es stated.
	To the Hospital or Attanding is within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edical	(Check only one) Similar Examiner: On the basis of axamination and/or investigation, in my opinion, deeth occurred menner stated.	red et the tima, o	lete and piece, end	due to the ceuse(s)
	To the Hospital within 24 hours a To the Funeral D completely filled I	×	29b. Signature and titla of coulifiar 29c. Licansa number	1.2.	29d. Dete signed (A	fonth, Day, Year)
4			KDZ0M200 MD 1)2/1/2	+4	- / ^ /	21.49
			30. Name and address of person who completed cause of deeth (Item 23a) (Type-Print)	, AL	RO	( I SNOWN
			KMJ, SAMIANI 7151 MSCAJA	Wory	ノフノ	C 4,4101
	Stat	te	31. Dete filed (Month Day, Year) 32. Registrar's Signeture			



Please Type or Print in Biack Indelibie ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND #1 PER MD. G775 9-2-99 J.A Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** hu 6:41 P.M. 1000 \* /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GARRETT OAKLAND GARRETT COUNTY MEMORIAL HOSPITAL 5 Social Security Number If Under 1 Year 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Dey, Year) 9. Birthplace (State or Foreign **Funeral** Months 10 M 2 F Days Hours OHIO 212-28-8729 66 Yrs DEC 28, 1932 Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits ms 23a or 28a-f show 1 ☐ Yes 2 No PRESTON TERRA ALTA Director 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? with USA BOX 151-1B 26764 RT.2 Funeral deeth 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. r than "natural", or Itams the Medical Examiner ma 11 Marital Status filed within 72 hours efter 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: WHTTE à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HEALTH CARE NURSING ASSISTANT . Pages 1 and 2 should be filed witness of Health and Mental Hygien tant: If Item 27 is marked other theirty or other traumatic event, Its 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) FANNIE MAE BOWERS PURTEE WESLEY Μ. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) TERRA ALTA, WV 26764 RAYMOND DASHEILLS - HUSBAND BOX 151-1B RT.2 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or 7/8/99 FAITH CEMETERY TERRA ALTA, WV 4 ☐ Donetion 5 ☐ Other (Specify) 22 Name and Address of Facility P.O. BOX 243 M00167 DURST FUNERAL HOME - OAKLAND, MD 21550 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Fine disease or condition resulting in death) Examiner Examiner physiclen end s the burief-trans Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or es a consequence of) requires that the death certificete be exec Division of Vital Records, P.O. Box 68760 Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of) 98 use Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? signed by the 2□ No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed Deen has page 2 1 ☐ Yes 2 No 1 ☐ Yes certificate or Attending Physician: funeral director. 25. Was case referred to medical axaminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient this 28d. Describe how injury occurred 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of Certification: 28c. Injury at Work? After 1 Vatural
2 Accident 5 Pending efter death. 1 Yes 2 No investigation 6 Could not be 3 Sulcide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homlcide 24 hours e Hospital Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) end menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted. 29a. Certifier Medical (Check only one) To the Y within 2 295. Signature and little of Certify 29c. License number 29d. Date signed (Mooth, Dev. Year)

State Registrar

X

31. Date filed (Month, Dey, Year)

SAVOPOULOS, M.D.

JUL - 7 1999

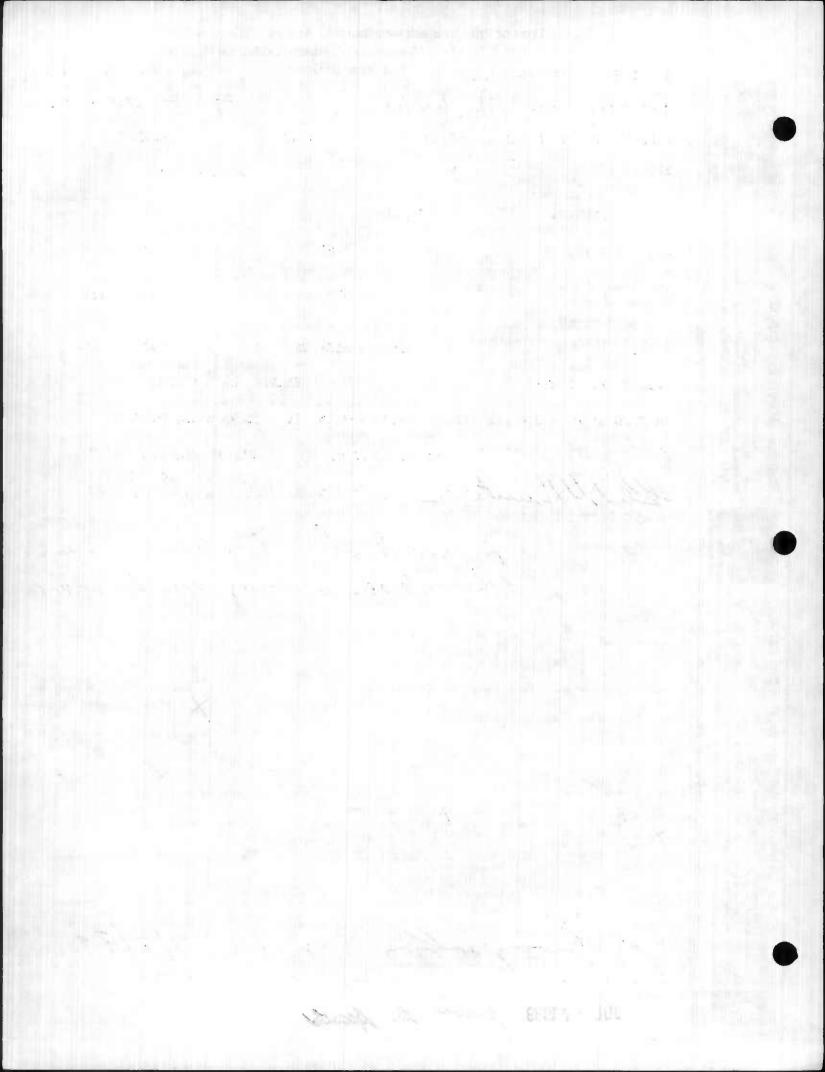
30. Name and address of person who completes cause of death (Item 23a) (Type, Print)

Personal Property Signature S. Source S.

1104 E. STATE ST.

26764

TERRA ALTA, WV



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Frederick John Eller July 8th 1999 8:30 PM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Crofton Convalescent & Rehab. Ctr. Crofton Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 6. Dete of Birth Dec. 12, 1918 Birthplace (State or Foreign Country) 1 M 2□ F 507-18-0588 80 Nebraska Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Maryland Anne Arundel Annapolis 10e. Street and Number 10f Zin Code 10g Citizen of What Country? 2569 Forest Knoll Road 21401 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 0 2 14. Rece - American Indien, Bieck, White, etc. 11 Marital Status 1 ☐ Yes 2 ☐ No 1938. If Yes, Give Year or Dates: 195/ 1 Never Merried 2 Merried 1 ☐ Yes 2 DXNo Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 8th V.P. Sales-East Region Foods 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Nick Eller Carrie Seberger 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mabel E. Eller/Wife 2569 Forest Knoll Road Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, cremetory or other place) 7 Pate / 9 920c. Location - City or Town, Stete 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Veterans Cemetery Crownsville, MD. 21. Signature of Funeral Service Licensi 22. Name end Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis2140 ou 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Deeth Immediete Cause (Finel disease or condition resulting in death) Internory disease ructure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown action 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 45 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 28b. Time of of Injury oth, Day Year)

The law requires that the death certificate be executed physician s the burial 88 080 signed by t certificate or Attending Physician:

this

filled in by

edicai

Hospital

within 2 \$

Box 68760.

P.O.

Division of Vital Records.

Examiner Physician/Medical by Completed Be Certification: To funeral After 24 hours after death.

Funeral Director: A

**Physician** 

/Medical

Examiner

Directo

Funeral

à

Completed

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**Funeral** 

Director

28a-f

items 23s or

8

the Medical Examiner

If item 27 is marked or other traumatic av

Department of Important: If any injury or

**Physician** 

/Medical

Examiner

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiens.

Baltimore, Maryland 21215-0020

the Maryland

axaminer? 1 ☐ Yes 2 No		Hospital	10
27. Manner of Death 1 Netural 2 Accident	5 Pending investigation	7.5	Date (Mor

investigation 6 Could not be determined

28c. Injury at Work? Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28d. Describe how injury occurred

29a. Certifier (Check only one)

3 Suicide

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signature and title of certifier

29c. License number

1 Yes 2 No

29d. Date signed (Month, Day, Year) 18

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Da Geet Singh 1413 Annaho Cu

ODENTON

21113

State Registrar

31. Date filed (Month, Day,

32. Registrar's Signature

101. 12 1999 June 1. August

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent'e Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month July **Physician** William Keith Enright 10 1999 4:15 PM /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street and number) 4c. County of Death Examiner Road Davidsonville Anne Arundel 2924 Davidsonville Hours Min. Aug. 9, 1938 If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 10 M 20 F Yrs Director 356-30-9362 60 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limite Maryland Anne Arundel Davidsonville 1 Yes 2 No Director 28a-f 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number 23a or 21035 United States 2924 Davidsonville Road Funeral Berns 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. filed within 72 hours after 1 Never Merried 2 Merried No Yes 2 No MY Yes, Give Year or Dates: 1956 1 Yes 2 ANO Specify: Baltimore, Maryland 21215-0020 Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) R.E. Sales Real Estate Agent 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Pages 1 and 2 should be nent of Health and Mental Dolores Finn William K. Enright, Sr. 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) MD 2924 Davidsonville Rd. Davidsonville 210 19e. Intorment's Neme/Reletionship (Type, Print) Gail M. Enright/ Wife of Health of Itsen 27 to other tra 20a. Method of Disposition 20b. Place of Disposition (Name of 7/12/99 20c. Location - City or Town, State For Lilionin Cremetory 1 ☐ Buriel 2 X Cremation 3 ☐ Removel from State = 8 Department of Important: If any injury or Brentwood, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home, Inc 21. Signeture of Funerel Service Lice 147 Duke of Gloucester St. Annapolis, MD 21401 Mary 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** diac Insufficience /Medical Immediate Ceuse (Finel MINUTES diseese or condition resulting in deeth) Examiner pertension The law requires that the death certificate be executed burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of): pul Box 68760, Physician/Medical physi that Due to (or as a consequence of): USB been signed by the a should be detached f P.O. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings available prior to Completed 24a. Wes an eutopsy performed? completion of cause of deeth? page 2 1 Yes 2 0 M 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: 25. Was case reterred to medical examiner? Be 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA this 27. Menner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 6 Could not be 3 ☐ Suicide 28t. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, tectory, office building, etc. (Specify) filled in by 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29e. Certifier Medical completely (Check only one) Within 2 To the 29b. Signeture and title of certifier reputy 29c. License number 29d. Date signed (Month, Day, Year) me and address of person who completed of death (Item 23a) (Type, Print) America 21035 ONES 31. Dete tiled (Month, Dey, Year) State Registrar

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State of Maryland / Department of Health and Mental Hygiene 9 2 L 3 | 7

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			1. Decedent's Nama (First, Middla, Las	f)				2. Data of De Month	ath Day	Yaar	3. Tima of Death		
	Physicia /Medica		Kenya Eldridge	9				7		999	1700		
	Examine		4a Fecility Nama (If not institution, give	straat and number)			4b. City, Town, or L	ocation of Daetl	4c. County	of Death			
			Anne Arundel	Medical (	Center		Annapol	is	Anne	Arur	ndel		
	Funeral Director		5. Social Security Number 220-84-2405 6. Security Number 1	ox 7. Age ☐ M 2 TF	(In yrs. last b	Yrs. If Under 1 Your Months De	ear If Undar 24 Hrs. lys Hours Min.	8. Data of Bir (Month, Da NOV.	th 19. Yaar) 7 1974	9. Birthp Coun Mar	place (State or Foreign orty) yland		
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	th with the	al Director	10e. Street and Number 425 Captains Ci	rcle Ap	ot. A	10f. Zip Coo 214			10g. Citizen of V	Vhat Cour	ntry?		
020	urs a	by Funeral	11. Maritel Stetus  1   Nevar Marriad 2 Married  3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1  Yas 2 N If Yas, Giva Yeer or Datas:	Ever in U,S.	13. Was Decedent If Yas, specify (	of Hispanic Origin? (S) Cuban, Mexicen, Puerto No Specify:	pecify Yas or No Ricen, atc.)	Biad	e - Americ ck, Whita, : Bla			
2121 d within giene. or than	within ene. than	Completed	15. Decedant's Ed (Specify only highest grad Elemantary/Secondary (0-12)	de com <i>platad)</i> Coilaga (1-4or 5		a. Decedent's Usual Oc (Giva kind of work do lifa. DO NOT usa re Secret	one during most of wor stired)	king			Arundel		
	* +		12th 17. Fathar's Nama (First, Middla, Last)	0			18. Mothar's Nan	na (First, Middle		-	41		
Maryland	od at b	To Be	Kenneth Eldridg	je			Elenor	Willi	ams				
ary		-	19a. Informant's Name/Ralationship (7	ype, Print)	15	b. Mailing Address (St.	reet and Number or Ru	ral Routa Numb	er, City or Town,	Stata, Zip	Code)		
	D - N -		Kenneth Eldridg	ge (Father	r) 8:	200 Stewa	rton Ct.	Severi	n, Md.	2114	44		
altimore,	0 - 5		20a. Mathod of Disposition  1  Buriel 2 Cremetion 3  4 Donation 5 Other (Specify		camat	of Disposition (Nama of ary, cramatory or other CHURCH (	place)	7-9-99	20c. Location -				
Balti	permit. Pag Department Important: I any Injury o		21. Signatura of Funaral Sarvice Licen	Leon	0.	Wm. Ree	ddrass of Fecility se And So	ons Mon	rtuary	P.7	A.		
			23a. Part1. Entar tha disassa, or comp shock, or heart failure. List only	olications that causad	tha death. Do	not antar tha mode of	dying, such as cardiac	or raspiretory a	rrast,		Approximate Intarval Between		
, i	Physician /Medical Examiner		Immediate Causa (Final disease or condition resulting in death)	· PRO	3ABL	E PULM consequence of):					Onsat and Death  MMEDIATE		
	p : 5	iner		b									
	cate be executed physician and s the buriel-trensit	Examiner	Sequantially list conditions, if eny, laading to immediate ceusa. Entar Undarlying Causa (Disease or injury		Due to (or as	consequence of):							
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Вох	attendir	ian											
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Vital Records,	law requires thet the as been signed by the 2 should be detached.	Completed by	RECENT BY				eremif	24a. Was	an autopsy ormed?	av co	/ara autopsy findings vailable prior to omplation of cause death?		
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/ita	certificate rector, per	Be	25. Was cesa refarred to medicel axaminar?				26. Placa of Dea	ath (Check only	one)				
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	Attending P or deeth. ector: After I by the funera	ation:	27. Mann of Death  1	28a. Data of Inju (Month, Day	y Year) 28b		tnjury at Work? 1 □ Yes 2 □ No	28d. Dascribe	how injury occur	red			
Division	s efter deeth	Certification:	3 Suicide 6 Could not be datamined	28a. Place of Inju- building, ato	28f. Location ( City or To		oer or Run	al Routa Number,					
	tospit 4 hou funer ely fill	edicai	29a. Certifier (Check only one)	yelctan: To the best of liner: On the basis of and mannar sta	axamination a	ge, death occurrad at the and/or investigation, in t	na tima, data and place my opinion, death occu	, and due to the rred at the tima,	cause(s) and made date and place,	annar as s end dua t	stated. to the cause(s)		
	within 2 To the P	M	29b. Signatura and title of certifiar	4	0.1.1	29c. Li	ensa number		29d. Date signe	d (Month,	Day, Year)		
			MCC	MON	NPH	0	38328		7-5-	-98			
			30. Name and address of person who o	completed cause of d	eath (ttem 23a	) (Type, Print)			1.	01	10115		
			30. Name and address of person who of 180 ADM   RAT	LCOCHY	ZANE	DRAW	NAPOLI	5 MD	14		TIVE		
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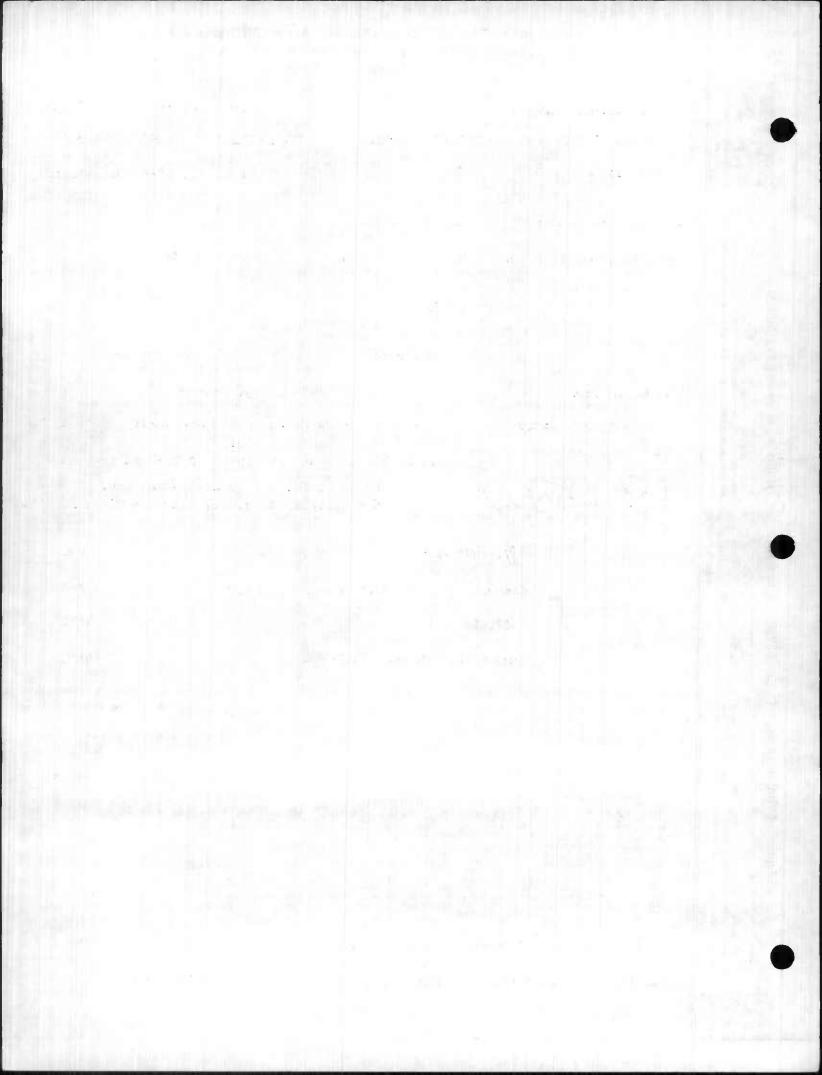
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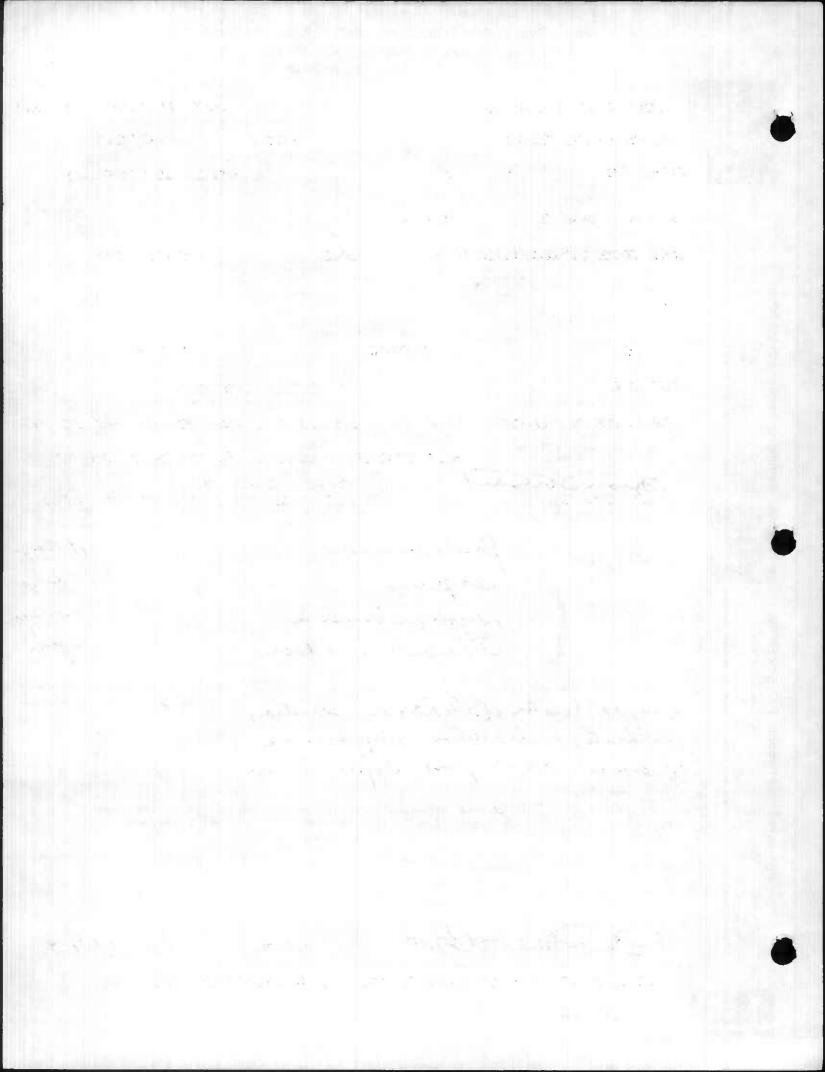
				Cer	tificate	e or i	Dealli			Reg. No.			
	1. Decedent's Name (First, Middle,	Last)							2. Dete of De	ath	W351	3. Tirr	ne of Death
Physician	Thomas Arthur E	skev							July 1	18, 1999 Year		6:	55pm
/Medical Examiner	4a Facility Name (If not institution,		ber)			4	b. City, To	wn, or Lo	cation of Deat			J J P III	
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Funeral			. Age (In yrs. last		If Under		If Under	24 Hrs.	8. Date of Bir	th			ate or Foreig
Director	579-34-2504 Usuel Residence of Decedent	1 ☑ M 2 □ F	72	Yrs.	Months	Deys	Hours	Min.	Aug. 1	3, 192	6 Wes	t Vir	gina
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or 28e-f shi be notified Director	Maryland Montgo	mery	Rockv	ille								Yes 2 N	
3e or 2 nt be nu al Dire	10e. Street and Number 5901 Montrose R	oad Ant 1	N1503		10f. Zip					10g. Citizer	of What Co	untry?	
Jers Jers	11. Maritel Status	12. Was Deced	ent Ever In U.S.	13. V			ispanic Orl	gin? (Spe	ecity Yes or No				n,
Health and Mental Hygiene.  Item 27 is marked other than "natural", or items 23s or 23s-f show other traumatic event, the Medical Estaminet must be notified at other traumatic event, the Medical Estaminet must be notified at other traumatic event, the Medical Estaminet must be notified at other traumatic event, the Medical Estaminet must be notified at events.	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☒ Divorced	Armed Ford  1 X Yes 2  If Yes, Give  Year or Dat	!□ No			ecedent of Hispanic Origin? (Specify Yes or specify Cuban, Mexican, Puerto Rican, etc.) es 2 XNo Specify:			Rican, etc.)		Bleck, White ecity: Wh:		
nature of call	15. Decedent's (Specify only highest	Education	ducation 16e.			l Occup	ation du <i>ring</i> mos	t of worki	ing	16b. Kind	of Business/	Industry	
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nd Mental Hygiene. I marked other than umatic event, the M To Be Comp	Arthur L. Eskey					Fleta Faye Greenelch							
is me	19a. Informant's Name/Reletionshi	p (Type, Print)							al Route Numb				
m 27	Diane Murphy /	Daughter					Have	n Dr	rive, M			The second secon	
Department of Haalth a important: If Itam 27 is eny injury or other tra	20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3  4 ☐ Donetion 5 ☐ Other (Spe		tate ceme	etery, crem	siti <i>on (Nam</i> latory or of <b>leave</b> 1	her plac	meter		uly22 999		ion - City or Spri		
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within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Medical Certification:		Physician: To the base	is of examination										use(s)
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State of Maryland / Department of Health and Mental Hygiene Q Q 21, Q 1 Q

						Ce	rtificate o	f Death		Reg. No.	2 6	4313	
	-	1. Decedent's Name (	First, Middle, La	st)					2. Date of Month	Death Day	Year	3. Time of Death	
	Physician /Medical	LEOLA AG	NES HIL	L EDELE	V				JU		1999	5:55 A.M	
	Examiner	4a Facility Name (If no			nber)			4b. City, Town,	or Location of De	eath 4c. Cou	nty of Death		
		CIVISTA ME					1 411 1 41	LAPLA			CHARLES		
	Funeral Director	5. Social Security Num 216-16-031	4 1	ex □M 2只F	7. Age (In yrs. 82		Months Day		lin. (Month,	Birth Dey, Year) 15, 191	Cou	place (State or Foreign ntry)	
Т	pue *	Usuel Residence of De 10a. State	ocedent Ob. County		10c. Cit	y, Town or Lo	ocation					10d. Inside City Limits	
	Vanyta 4 sho	MARYLAND	CHARLE	S		WBURG					Yes 2□No		
	ith the Ma or 28a-f s be notified	10e. Street and Number		<u> </u>	141	MDOIG	10f. Zip Code	)		10g. Citizen of What Country?			
	3a or	14630 SOUT	H CTICKO	LDS CREE	TK ROAD		2066	54		UNITOE	D STAT	TEC	
	r tems 234	11. Marital Status		12. Was Dece Armed Fo				f Hispanic Origin? uben, Mexican, Pu	(Specify Yes or		leca - Ameri	can Indian,	
215-0020	or or or	1 ☐ Never Married 3 🛣 Widowed 4 [		1 Yes It Yes, Giv Year or Da	2⊠No e		1 ☐ Yes 2 ☑ N		eno rican, etc.)		Black, White,		
5-0	naturef,		i. Decedent'a Ed only highest gra			16a. Dece	dent's Usual Occ	upation e durina most of	workina	16b. Kind of	Business/In	dustry	
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Maryland	Sep 9		st, Middle, Last)								iarrie)		
7		JOHN HILL  19a. Informant's Name	/Palationship /	Tuna Printi		10h Maili	na Address /Stre	BERTHA et and Number or	GREEN I		un State 7ii	Code)	
a,	tem 27 is	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location completely, crematory or other place)										RYLAND 2066	
Ein	Pages ment of lant: If its lury or o	4 ☐ Donation 5				Y GHOS	T CHURCE	H CEMETE	RY 7/26/	99 ISS	UE, MA	ARYLAND	
Baltimor	permit. Pages Department of Important: If is any Injury or once.	21. Signature of Funer	HORNTON	1500		T		ress of Facility FUNERAL INGSTON			AD MI	20640	
		23a. Part1. Enter the shock, or heart to		plications thel co	aused the deal	h. Do not en	ter the mode of d	ying, auch as care	diac or respiretor	y errest,	ابد رسم	Approximate Interval Between Onset and Death	
1	Physician		,	,	3		v.						
a	/Medical Examiner	Immediate Cause (Findisease or condition	al	. 9.	neu	mo	nea	2				11 days	
	ž line	resulting In death)		/	Due to (	or as a conse	quence of):					15 days 15 days 15 days	
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60,	be ey ician buria											13 day	
Box 68760,	= 00	resulting In death) Las	· L	· Z	e Cu	buti	quence of):	leer	~			1 year	
. B	for for	Part II. Other significa	nt conditions c	ontributina to de	ath but not res	sulting in the s	Inderiving cause	given In Part I.	23b. E	old tobacco use	contributs 1	to the cause of death?	
P.0	that the de ed by the detached	110,000	3.	de	00	la.	: 0	2. T	1	□Yes >SN	o 3 Pro	bebly 4 Unknown	
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Vital		25. Was case reterred	to medical				//	26. Place of	Death (Check or	ly one)			
fν	S S D D	exeminer? 1 ☐ Yes 2 📆 No		Hospital:	npatient 2	ER/Outpatie	nt 3 DOA	Other: 4 🗆 Nursin	g Home 5□R	esidence 6	Other (Speci	ify)	
ion of	Attending Phor death.  ector: After this by the funeral	27. Manner ot Death  1 Naturel  2 Accident	5 Pending Investigation		t Injury h, Day Year)	28b. Time of Injury	V	jury at Vork? ☐ Yes 2 ☐ No	28d. Descri	be how injury oc	curred		
Division	tal or Attending P after the last Director: After the last Director: After the last in by the funers Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	208. PIECE	ot Injury - At h ng, etc. <i>(Speci</i>	ome, term, st	reet, factory, offic	00	28t. Location City or	n (Street and Nu Town, Stete)	mber or Rui	ra/Route Number,	
	Hospi 4 hour Funer tely fill	29a. Certifier 15 (Check only one) 2	yaician: To the niner: On the ba and mann	time, dete end pl y opinion, death o	ece, and due to courred et the tir	the cause(s) end ne, date and place	menner as: ce, and due	stated. to the ceuse(s)					
4	To the within 2 To the comple	29b. Signature and the	of certifies	th	th	m	29c. Lice	D-0837	0	29d. Date signed (Month, Day, Year)			
		30. Name and address	ot person who	completed caus	e of deeth (Iter	n 23a) (Type	Print)	וכטט ע	0				
		PAUL E.	PRITCHE	TT MD 1	18 LAGI	RANGE	AVE. P.O	. BOX 13	17 LAPL	ATA MD.	20646		
	State	31. Date filed (Month,	Day, Year)	32. R	odstrar's Sign		has	del			N IV		
	Registrar	Jl	L 2 3 1	999		10	· Marie						

DHMH 16 Rev 6/95



			Maryland / Dep		Assure All Copies ealth and Mental HyDeath	_	4320					
1	Physician /Medical	1. Decedent's Name (First, Middle, Last)  JOHNE, Ellingsen	Sr.		2. Date of Death Month Day Year July 24 1999 1931							
	Examiner Funeral Director	the City Town or Location of Dogston of Dogs										
020  irs after death with the Maryland if, or herre 23e or 28e-f show Cashioer must be notified at	Maryland of show fled.at	Usual Residence of Decedent  10e. State 10b. County  MD Caroline	10c. City, Town or L			10d. Inside City Limits 1 ☐ Yes 2 🖔 No						
	th with the Ma 23a or 28a-f at be notified at Director	100. Street and Number 1032 North Heritage	Court	Dento 101. Zip Code	1629	10g. Citizen of What Co						
	er, or Esam by F	11. Maritel Status  1 Never Married 2 Merried  3 Widowed 4 Divorced  12. Wes Deceder Armed Force 1 Yes 2 Figure 1 Yes, Give Year or Date:	No	Was Decedent of His If Yes, specify Cuber 1 ☐ Yes 2 ☑ No	panic Origin? (Specify Yes or N , Mexican, Puerto Rican, etc.) Specify:	o- 14. Race - Ame Black, Whit	erican Indian,					
215-0	ed within 72 ho vglene. wer than "naturn it, the Medical.] Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4c)	(Give	edent's Usual Occupa a kind of work done do DO NOT use retired)	uring most of working	16b. Kind of Business						
nd 21	tal Hygien d other th event, the	12 2 17. Father's Name (First, Middle, Last)	St	ationary	Engineer 18. Mother's Neme (First, Middle		cturing					
Maryland 21215-0020	d 2 should by and Marit	Hans Torvald Ellings  19a. Informant's Name/Relationship (Type, Print)	ing Address (Street a	Olga Kristina Johansen Street and Number or Rural Route Number, City or Town, State, Zip Code)								
Baltimore,	Pages 1 and tent of Heall of Heall of Heall of Heall of the Z	01ga Penrod/Daughter  20a. Method of Disposition  1□Burial 2 © Cremetion 3 □ Removal from State  4□Donation 5 □ Other (Specify)	0			20c. Location - City or						
Balti	permit. Departm Importa any Inju	21. Signeture of Funeral Service Licensee  22. Name and Address of Facility  Paramptom-Hawkins-Eskow Funeral Home P.O. Box 43, Federalsburg, MD 21632  23e. Pent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Onset and Death										
	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  A HEOUT Failute										
_	executed in and tal-transit Examiner	Cause (Disease or Injury										
x 68760, ertificate be execut	g physicia as the bur ledical											
, P.O. Box	d by the setache	Part II. Other algorificant conditions contributing to death  Hyperteus/E	but not resulting in the o	underlying cause give	n in Part I. 23b. Dic	to the cause of death? Trobably 4 Unknown						
Records,	8 8 S	Hypercholest	erelem	la	peri	ormed?	Were autopsy findings available prior to completion of cause of death?					
Vital	hysician: The his certificate of director, pag	25. Was case referred to medical exeminer?  1   Yes   2   No   Hospital:	itient 2 ER/Outpatie	ont 3 DOA Othe	26. Place of Death (Check only	one)						
o è		27. Nenner of Death  1 Neturel		M 28c. Injury Work 1 Y	at 28d. Describe	ural Routa Number,						
۵	To the Hospital or within 24 hours afte within 24 hours afte completely filled in Medical Cert	29a. Certifier (Check only    Certifying Physician: To the basis	st of my knowledge, deet of examination end/or in	th occurred at the time	a, date and place, and due to the	e cause(s) and manner a	s stated. e to the cause(s)					
	To the comple	one) and manner stated.  29b. Signature and fille of certifier 29c. License number 29d. Date signed (Month, DOS4576 07/24/										
	State Registrar	30. Name and address of berson who completed cause of Rachel Butdick 16 31. Date filed (Month, Day, Year)  JUL 2 7 1999	1 Thompse		st Saint L	lichaels	Yaryland					

DHMH 16 Rev 6/95

oor o the

State of Maryland

<b>J</b> /	Department	of Health and	mentai	Hygiene
	Certificate	of Death		Reg. No.

1. Decedent's Name (First, Middle, Last) **Physician** 

Director

Funeral

ģ

Completed

Be

20

ELIZABETH FEROLDI

ELIZABETH WOODWARD FEROLDI

1 M 2 F

2. Date of Death Month JULY

3. Time of Death

1 ☐ Yes 2 No

/Medical Examiner

NEBEL STREET ON RANDOLPH ROAD 5. Sociel Security Number 7. Age (In yrs. last birthday)

4a Facility Name (If not Institution, give street end number)

40

4b. City. Town, or Location of Death

BETHESDA

Day 9,1999 3:42P.M. 4c. County of Death

MONTGOMERY

**Funeral** Director

28a-f show

ò

Barrie 23a

b

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within

Health and Mental is marked

Department of Health a Important: If Item 27 is any injury or other tra

**Physician** 

/Medical

Examiner

nding physician a

signed be del

certificate

this

After

þ

Completed

Be

Certification: To

edicai

The law requires that the death certificate be executed

Box 68760,

P.0.

Records.

Division of Vital

Hospital or Attending Physician:

To the

death.

after death

within 24 hours a To the Funeral D completely filled

0

filled in by

Usual Residence of Decedent 10b. County

If Under 1 Year | If Under 24 Hrs. Months Days Hours

8. Date of Birth (Month, Day, Year) March 17,1959

9. Birthplaca (State or Foreign Country) New York

10a, State

089-40-9105

Virginia Fairfax 10c. City, Town or Location Vienna

10d. Inside City Limits

USA

10e. Street and Number

9850 Hidden Estates Cove

10f. Zip Code 22181-6090 10g. Citizen of What Country?

12. Was Decedent Ever in U,S. Armed Forces?

13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.)

14. Race - American Indian, Black, White, etc. White Specify.

1 Never Merried 2 Married 3 ☐ Widowed 4 ☐ Divorced

1 Yes 24 No If Yes, Give Year or Dates:

1 Yes 2 No Specify: 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12)

College (1-4or 5+)

Account Executive

Hewlett-Packard

17. Father's Name (First, Middle, Last)

Kenneth G. Woodward

18. Mother's Neme (First, Middle, Maiden Sumeme)

Jean Powell

19a. Informent's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

John R. Feroldi/Husband 20a. Method of Disposition

20b. Plece of Disposition (Name of cemetery, crematory or other plece) Metropolitan Crematory

9850 Hidden Estates Cove, Vienna, Va. 22181-6090 Date 20c. Location - City or Town, State

Alexandria, Va.

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Euneral Service Licenses

22. Name and Address of Facility

MONEY & KING VIENNA FUNERAL HOME, INC.

7/14/99

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset end Death

Immediate Ceuse (Final disease or condition resulting in death)

Mulhilu Frjuries

Due to (or as a consequence of):

Physician/Medical Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last

Due to (or as e consequence of):

Due to (or as a consequence of)

Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 SHo 3 Probably 4 Unknown

24a. Was an eutopsy

24b. Were autopsy findings available prior to completion of cause of death?

1QYes 2□No

performed'

1 Yes 2 No

25. Was case referred to medical 1XYes 2□ No 27. Menner of Death

5 Pending investigation

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 28b. Time of 7-9-99 15 42

28c. Injury at Work? 1 ☐ Yes 2 ☑ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) TRAIN
TRACKS
Unjury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) TRAIN
TRACKS Truh SMULL

3 Suicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Rai Lucy Tra 4 Homicide Trucks 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) SWELL Nesel

(Check only one)

David

1 Natural

2 Accident

1 Certifying Physician: To the best of my knowledge, death-occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and proper stated. 29c. License number 29d. Date signed (Month, Day, Year)

26. Place of Death (Check only one)

29b. Signature and title of certifier

O.C.M.E.

JULY 10,1999

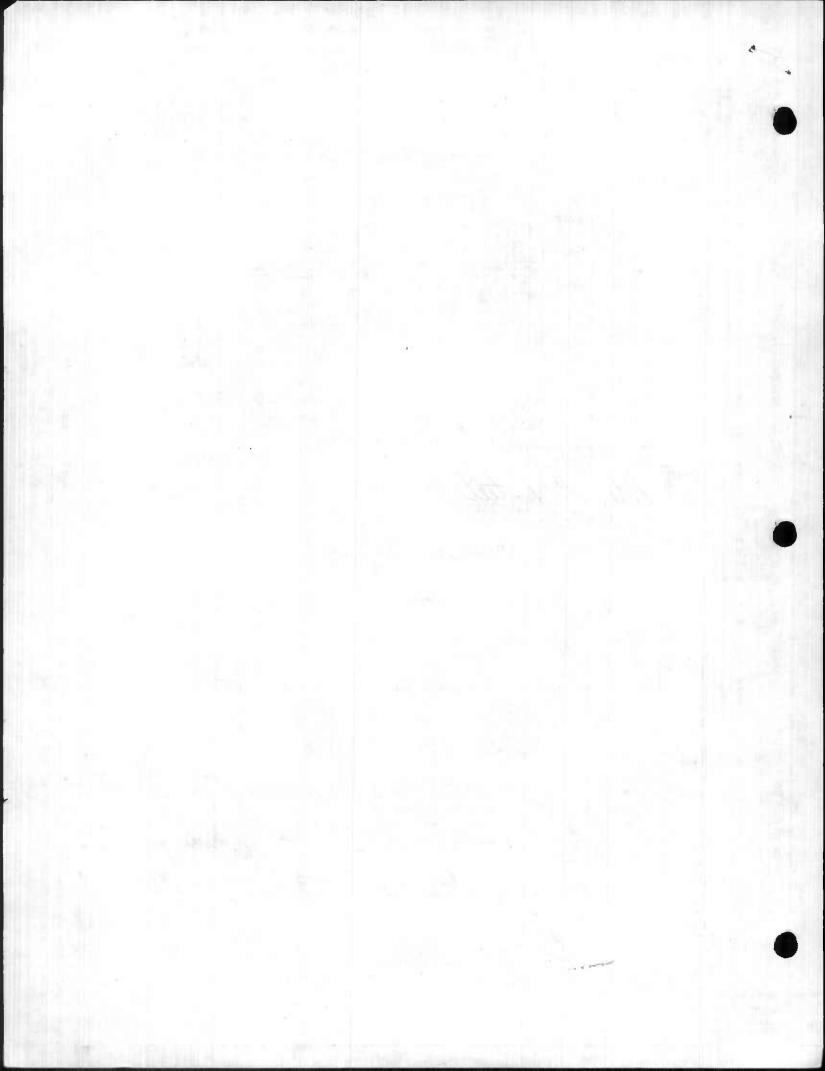
29a Certifier

30. Name and address of person y ho completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Dey, Year) JUL 19 1999 Foruer 32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene 0 0 21, 222

				ary larie /					to the	9 4	4366	
Division.		1. Decedent's Nama (First, Middle, Last)					2. Dete of Deeth Mooth Day Y			3. Time of Death		
Physic /Med		Darrell W. Fletcher					_			5:25 am		
Exami												
(1)			Darrell W. Pletcher    Supply See street and number									
Funeral Director		219-12-4383						8. Date of Bin (Month, De Augus	y, Year) 5 3,19	9. Birthp Court	laca (State or Foreign try) ashington	
land wa											Od. Inside City Limits	
ne Mary	etor	MD Anne Arundel Severna Park									1 ☐ Yes 2 No	
ath with ti	Funeral Director	100. Street and Number 111 Lock Leven Drive 21146							US	A		
d 21215-0020 filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or flems 23s or 28=1 show nnt, the Madical Examine must be notified.	by	11. Marital Stetus  1 Never Married 2 Msrried  3 XWidowed 4 Divorced	Armed Forces  1 □ Yas 2 □  If Yes, Give	No				ecify Yas or No Rican, etc.)		ck, White,	etc.	
5-0 72 hc	eted	15. Decedent's E	ducation ade completed)	166	(Give k	ind of work done	during most of work	ina	16b. Kind of I	Business/Ind	Justry	
d 21215-0020 filed within 72 hours aff Hygiene. ther than "natural", or ant, it a Wedical Exam	Completed	Elementary/Secondary (0-12)	College (1-4or	5+) I	IITO. D	ONOT use retired)			Corporate Sales Mgr.			
Maryland 212: d 2 should be filed within th end Mental Hygiene. 7 Is marked other than traumatic event, tre.	To Be C	17. Fether's Name (First, Middle, Last Thomas	)	etcher								
laryian 2 should be end Mental (a marked o					b. Mailing	Address (Stree	t end Number or Rur	el Route Numbe	er, City or Town	n, Steta, Zip	Code)	
of Health e Item 27 le		Jaclynn Fletcher	/ daughter					Annapo	lis, MD	214	03	
2 2 2 2							Jice)	_				
Baltimo		21. Signature of Funeral Service Liousage 22. Name and Address of Facility										
		23s Part Thin the disease, or com	plications that cause	d the deeth. Do						alk,	Approximete	
Physician		shock or heart feilure. List only one cause on each line.  Interval Between Onset and Death										
/Medical		Immediate Ceuse (Final disease or condition	end	stage	di	1ctal	conduc		TL		2 0	
Examiner		resulting in death)	a.			ience of):		/ /	1			
P ₹	ine		b									
and and I-tran	хап	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying										
68760, ficata be ex physician is the burie	<u>e</u>	Ceuse (Disease or Injury that Initieted events resulting in death) Lest  Due to (or es a consequence of):										
	ledic											
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death death of for	Completed	Part II. Other significant conditions of	ontributing to death b	out not resulting	in the un	derlying cause g	ven in Part I.	23b. Dld	tobscco use c	ontribute to	the cause of death?	
is, P.O. Box as that the death cert igned by the attendin be detached for use						95	1 ☐ Yee 2A No 3 ☐ Probabity 4			bebty 4 Unknown		
Sord requir		sleep apure					,	24a. Was	an autopsy rmed?	ev	eileble prior to mplation of causa	
Recamber law		,							Van aleks			
Vital Pictan: The certificate rector, pag		25. Was case referred to medical					Of Place of Past			1	_ 16s 2 No	
		examiner?	Hospitat:	ent 2 DEB/C	utnetient	3 DOA O	hor			ther (Specif	v)	
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nding lath.	atio	2 ☐ Accident investigatio	n	sy rear)	Injury							
Division  or Attending after death. Director: After d in by the fune	ertific	determined 286. Pleca of Injury - At nome, farm, street, fectory, office 261. Location (Street and Wumber of P								ber or Rura	Il Route Number,	
Division  To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	edical Ce	(Check only 2 Medical Exam	niner: On the basis of	of examinetion e	je, death nd/or inve	occurred et the t estigetion, in my	me, dete end place, opinion, deeth occur	end due to the red st the time,	ceuse(s) end n dete and place	nenner as s	tated. the cause(s)	
o the	2	29b. Signature and title of certifin				29c. Lican	sa number		29d. Date sign	ed (Month,	Dey, Year)	
6-11-4		PAV	) ~	M		173	8158		7/9	199		
		30. Name and editress of nerson who	completed cause of	teeth (Item 22a)	(Type 5	2				11)		
		2003 Medical		mr Aru		M 2140	1 D.	- Lisa	Din.	AR Z	P	
St	ate	31. Dete filed (Month, Dey, Yeer)	32. Regist	rer's Signature	4	-				,		
Regist	rar	JUL 141	999	,	N.	Spar	Carl					

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1 P	ER PHY. AACO HE	ALTH DEP	T 7/14	Cost	ificate of	Death	cmh		-	) Con		
			emina.	lr				Month	Dey 1 0 0 0	Year		
		Description of Description Country  ON BROWN -PLEMPHTTS: Fleming Jr.  A. M.  A. M.  CROSS NURSING AND REHABILITATION CENTER BURTONSVILLE  ON Country  ON COUNTRY										
	HOLY CROSS NURSIN	G AND REHA	BILITAT	ION	Center of Death   Center   C							
	5. Sociel Security Number 6. 5	Sex 7. Age	e (In yrs. last bir	14   GREAT   Great								
r		XX	72	Yrs.				Jan. 5,	1927	North	n Carolina	
		PHY AACO HEALTH DEPT 7/14 Additional Common	1	IOd. Inside City Limit								
tor	Maryland Prince	George	Hyatts	svil	le						1 Yes 2□N	
Jr.	10e. Street and Number				10f. Zip Code			The Reg. No.    2. Date of Death   Dely   Year   S. Time of Death   Month   Doly   Year   JULY   10, 1999   4 A.M.     or Location of Death   4c. County of Death   4 A.M.     or Location of Death   4c. County of Death   MONTGOMERY     or Location of Death   4d. M.     or Location of Death   4d. County of Death   Month, Day, Year   Jan.   5, 1927   North Carolina				
in in	4005 Remington Ct	•			20782	2		-	US	A		
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		WW. O'.		10	Yes 2110	Specify:			Specify	. Wh:	ite	
		Tantille Families F		Decede	nt's Usual Occu	pation		10	5b. Kind of Bu	ısiness/în	dustry	
2				(Give ki	nd of work done	during most	of workin	g				
				Profe	essor				Univ	ersit	3. Time of Death 4 A.M.  RY place (State or Foreign intry) h Carolina  10d. Inside City Limits 1 Ryes 2 No intry?  Ican Indian, etc. ite ndustry  ty  p Code) 2  Town, State N.C.  1 Home MD 21401  Approximate Intervel Between Onset and Death 48 Hr.  4 Years  to the cause of death? phabity 4 Unknown  Were autopsy findings veilable prior to ompletion of cause of death? Yes 2 No  ify)  ral Route Number, stated. to the cause(s) Day, Year)	
									aiden Surnam	10)		
						_						
	20e. Method of Disposition		20b. Place of	Disposit	tion (Name of		-	Date 20	Oc. Location -	City or To	own, State	
				_			17	/14/99	Hender	son,	N.C.	
		_	A									
	P- Kun	Valel	9	14	7 Duke o	of Glo						
	23a. Part1. Enter the disease, or com- shock, or heart feilure. List only	plications that caused	the death. Do r							1	Approximate	
		Childret Off The Barber								1	Onset and Death	
	Immediate Cause (Finel disease or condition	Pneumo	nia							-	48 Hr.	
	Tooding in Coding		-							1		
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	resulting in death) Last	Total Control								i		
		d								1		
	Part II. Other aignificant conditions of	contributing to death bu	it not resulting in	the und	lertying cause gi	ven in Pert I.		23b. Did tob	ecco use co	ntribute t	o the cause of death	
Physician Medical Examiner  1. Decedent's Name (First, Middle, Last)  LEON BROWN FLEMMING  1. Decedent's Name (First, Middle, Last)  LEON BROWN FLEMMING  1. Sociel Security Number  1.						1 Vet	2 □ No	3 Pro	bebly 4 ☐ Unkno			
5			Res. No.  2. Date of Death Day 1999 Year 1, 1997 Year 1, 1999 Year 1, 1997 Year 1, 1999 Year 1, 1997 Year 1, 1997 Year 1, 1997 Year 1, 1999 Year 1, 1997 Year 1, 1999 Year 1,									
							_	performe	ed?	CO	impletion of cause	
								1□ Yes	2 No	1[	☐ Yes 2☐ No	
						26. Place	of Death	(Check only one	)			
		Hospitel: 1 Inpatie	nt 2 ER/Ou	tpatient	3□ DOA Ot	her: 4 Nu	rsing Hon	ne 5 🗆 Residen	ce 8 DOth	er (Specif	(y)	
		28a. Dete of injur (Month, Day			28c. Inju Wo	ry at	2	8d. Describe how	injury occur	red		
	2 Accident investigation					Yes 2 □ !						
	determined	Zoe. Piece of inju		rm, stree	t, factory, office		2	8t. Location (Stre City or Town,	et and Numb State)	er or Run	al Route Number,	
	29e Certifier 1P Certifying Ph	veicien: To the hest o	f my knowledge	death o	socured at the ti	me data and	d place a	nd due to the ceu	seals) and ma	0000 00 0	teted	
	(Check only 2 Medical Exar	niner: On the basis of	examination and	d/or inve	stigation, in my	opinion, deat	th occurre	d et the time, dat	e and place,	and due to	o the cause(s)	
	29b. Signature end title of certifier				29c. Licens	se number		290	d. Dete signe	d (Month,	Day, Year)	
	A				1)(	119	33	/	July	12,	1999	
	30. Name and address of person who	completed cause of de	eath (Item 230)	Type, Pr	WINT)	, , ,	1		3			
	R. Shumacher MD	2309 Shor	efield 1	Rd.	Wheaton	n, MD	2090	2.				
	31. Date filed (Month, Day, Year)	32/Registre	r's Signature	7								

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Dete of Death Month Day **Physician** 4:00 am Ruth Disney Finegan July 8, 1999 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Pasadena Oak Lodge Assisted Living Anne Arundel If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 217-05-7787 If Under 1 Yeer 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months 1 M 20 F 89 Maryland Yrs Director July 26, 1909 Usuel Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at MD Anne Arundel 1 Yes 2 No Director Pasadena 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 21122 USA 7753 Outing Avenue Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Yes 21 No
If Yes, Give
Yeer or Detes: 1 Never Merried 2 Merried altimore, Maryland 21215-0020 1 Yes 2₺ No Specify: White Specify à 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usuet Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Enoch Pratt Library filed within Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien, important if flem 37 is marked other the Librarian 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Walter McCrea Disney Florence Johnson 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter Severn JONES NEPHEW 5531 Wells Cove Drive, St. Leonard, MD 20685 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition July 12 20c. Location - City or Town, Stete 198 Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Burnie, MD 4 □ Donation 5 □ Other (Specify) Glen Haven Cemetery 1999 Barranco & Sons, P.A. Severna Park Funeral Home 21-Stghalure of Funeral Sovice License 495 Gov. Ritchie Hwy., Severna Park, MD on not enter the mode of dying, such as cardiac or respiratory errest, Approximate tnterval Between Onset end Death Physician Cardio Vanadar D Immediate Cause (Final despite or condition seculting in death) /Medical Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Last Due to (or as a consequence of): physician the burla Box 68760 Physician/Medical Due to (or as a consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Onknown by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 26. Place of Death (Check only one)
Other: 4 Nursing Home 5 Residence 6 Other (Specify) ASSISTED Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 10 1□ Yes 2☑ No this 28d. Describe how injury occurred 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: To the Hospital or Attending I within 24 hours after death.
To the Funerel Director: After 1 Netural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and menner stated. 29e. Certifier edical (Check only one) 29d. Dete aighed (Month, Day, Year) 29b. Signature and talk of certifie

State Registrar

30 Name and address of person who gompleted cause of de

JUL 0 9 1999

31. Dete filed (Month, Day, Year)

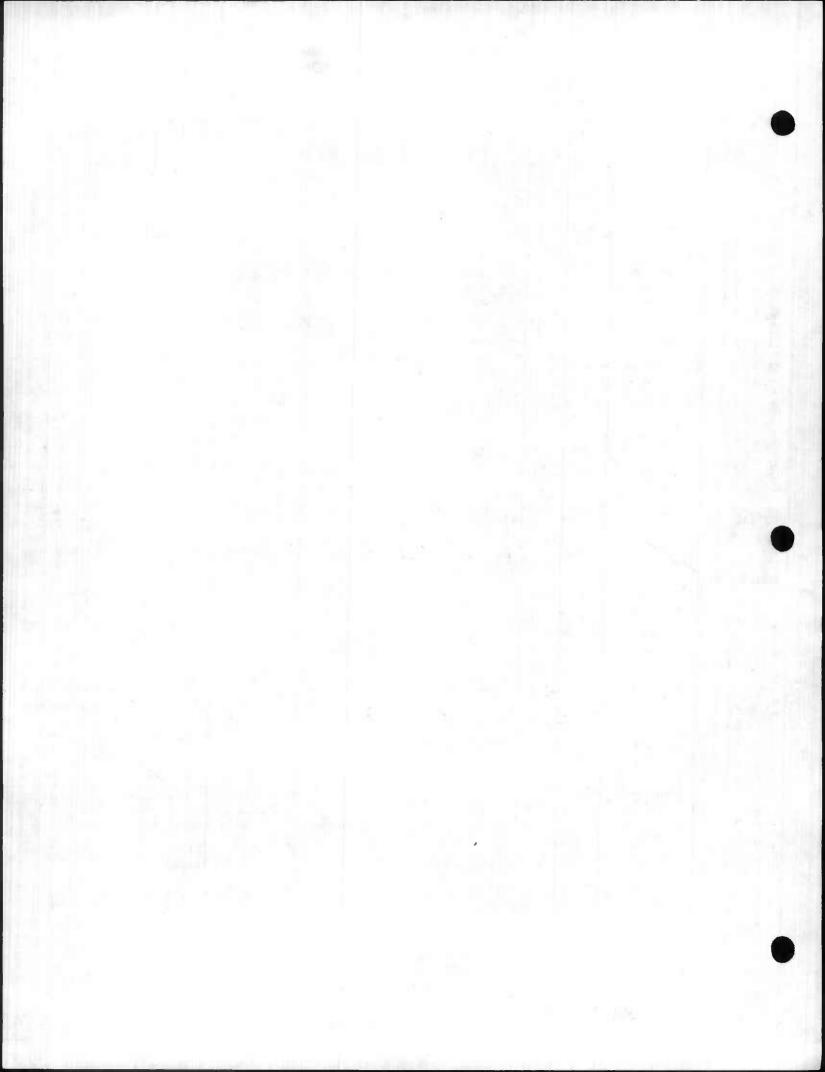
DHMH 16 Rev 6/95

**ORIGINAL** 

un.

(tem 23a) (Type, Print)

gistrar's Signeture



State Registrar

31. Data filed (Month, Day, Yaar) JUL 20 1999

29b. Signature and titla of certifian

ruclion

(Check only one)

30. Nama and addrass of person who completed cause of death (Itam 23a) (Type Print)

Tamana S. SEKHAN. 2401 Research Blud #102, Rockvelle, MD 20550 32. Registrar's Signatura Sepera

MD

2 Medical Examiner: On the besis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated.

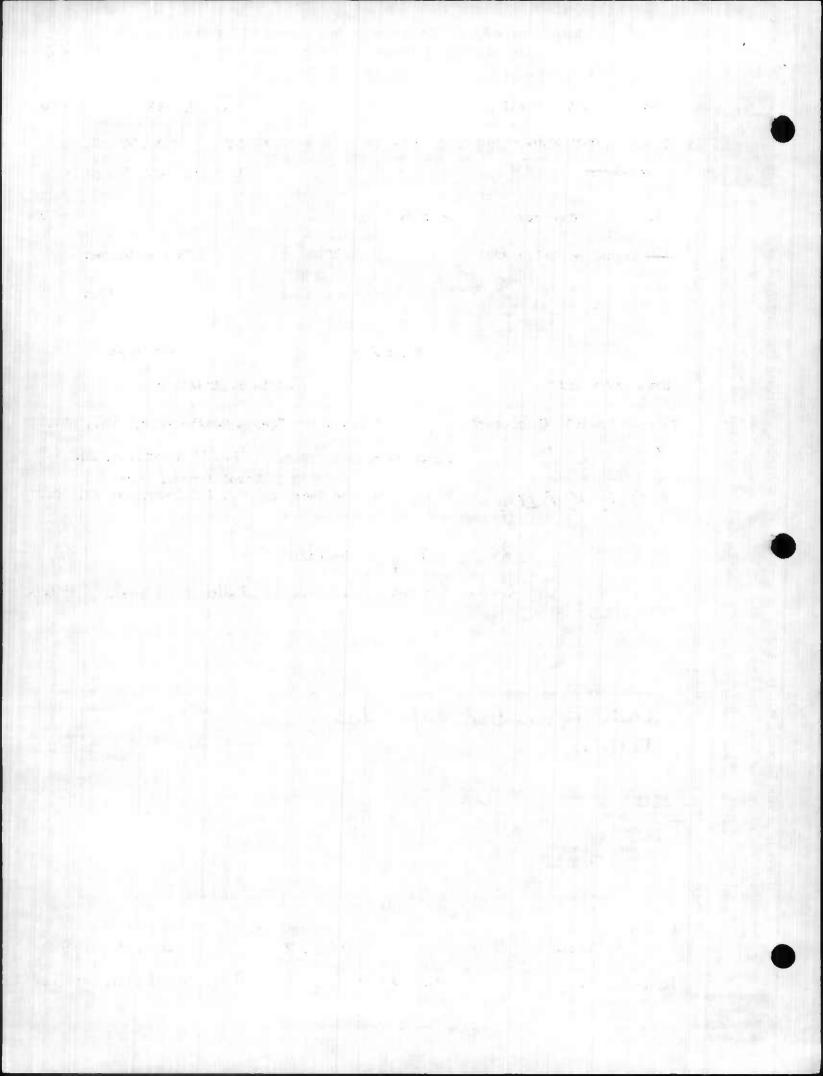
29c. Licansa number

05/7/4

29d. Data signed (Month, Day, Year)

**DHMH 16 Rev 6/95** 

To the vithin 2

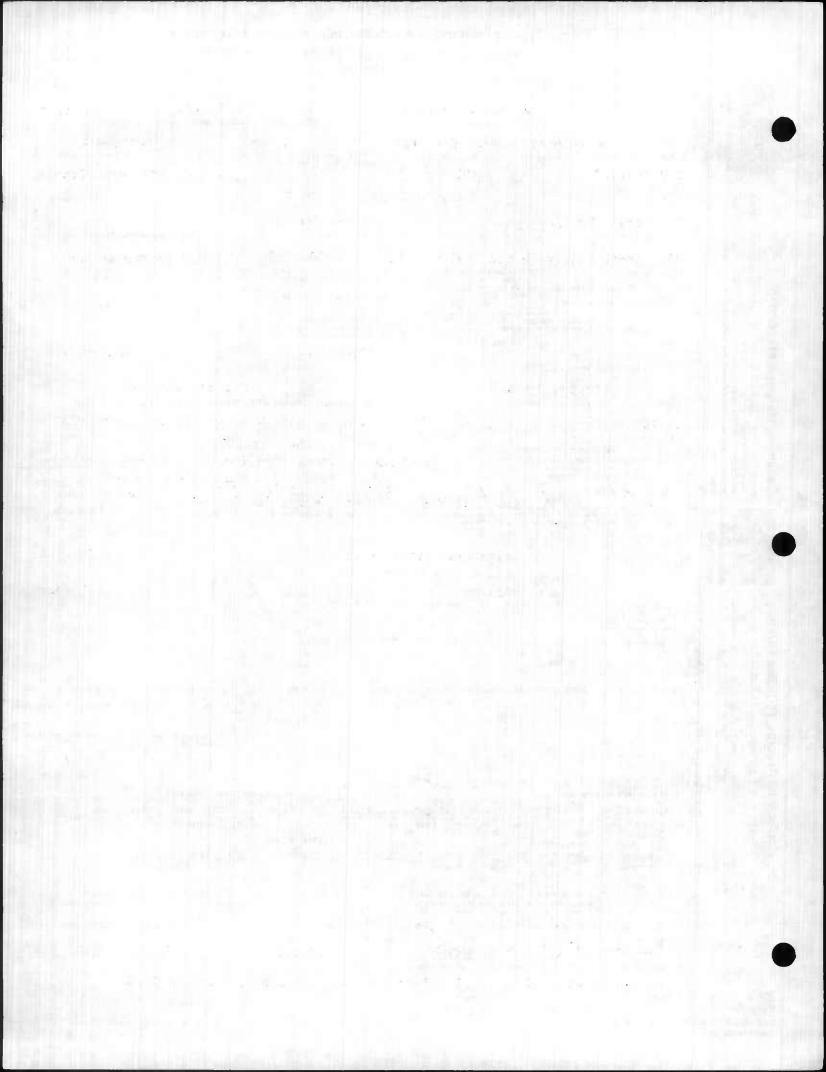


				Certificat	eor	Dealli		Reg. No.						
	Neme (First, Middle	, Last)			2. Date of Dea	Death Day Year		3. Time of Death						
n al		Albert	G. Fiedl	er						3:15 am				
	me (If not institution,	, give street and numb						4c. County	of Death					
	Montgo	mery Gener	al Hospit	al		Olney	7	Mor	ntgome	ry				
5. Social Secu			Age (In yrs. last bit		r 1 Year Days	If Under 24 Hrs. Hours Min.				ce (State or Fore				
577-58-	-2560	1₽M 2□F	M 2□ F 102		Days	Hours Mill.	January	4, 1897	Pennsy	ylvania				
10a. State	10b. County		10c. City, Tow	n or Location					10d	1. inside City Lim				
Maryla	nd Mont	gomery		Silv	ver	Spring				1 ☐ Yes 2 🔼				
Marylan 10e. Street and	d Number		10g. Citizen of V	Vhat Country	y?									
	3383 South Leisure World Boulevard #B1 20906-1758 United S													
3383 Se 11. Merital Ste 1 □ Never		12. Wes Decede Agned Force				Ilspanic Origin? (Span, Mexicen, Puerto	pecify Yes or No		e - American	indian,				
	Married 2 Marrie	ed 1 1 Yes 2	Yes 2 ☐ No es. Give 1 ☐ Yes 2 Ñ No Specify:					Specify	k, White, etc					
8	15. Decedent	's Education	/ear or Dates: WW I  n   16a. Decedent's Usual Occupation   16b. Kind of											
O Flomenta d	(Specify only highes		0.5.)	(Give kind of wo	ork done ise retire	during most of world)	king							
5 Elementary	/Secondary (0-12)	College (1-4	01 5+)	Eng	gine	er		U.S.	Govern	nment				
	ame (First, Middle, L													
0 17. Fathers No	Gusta	u Fiedler					Bertha	Jakemit	e					
-	it's Name/Relationsh		198	o. Meiting Address	s (Street	and Number or Ru				code)				
		Granddaugh				s Road Wa								
20a. Method o		Granddaugn	20b. Place o	of Disposition (Ne	me of	5 Road wa	Date	20c. Location -						
1 🗆 Buria	2 Cremation	3 Removal from Sta				July 21		200. Coodion	on, or	iii Oidio				
	tion 5 Other (Sp		Mor			matorium		-	thesda, Maryland					
21. Signeture	22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Ch M00335  22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Ch Sethesda, Maryland 20814-3501  Chase, Inc.													
1	1. 9	1 alest	M00335	7557 W	isco.	nsin Aver	196814-3	501 C	hase,	Inc.				
23a Fartt E	mer the differse, det	complications that cau goly one cause on eac	sed the deeth. Do	not enter the mod	de of dvir	ng, such as cardiac	or respiratory el	rest.	A	Approximete ntervat Between				
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Registrar

State

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** Harriet E. Fowkes 17, 1999 Ju<sub>1</sub>y 10:45 PM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Takoma Park Montgomery Washington Adventist Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Data of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 1 F Months Hours Yrs 90 Director 213-40-9650 February 24,09 Ohio death with the Maryland 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits r 28a-f ahow 1 ☐ Yas 2 ☐ No Director Maryland Prince Georges' Mt. Rainier 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 3105 Perry Street Funeral 20712 al Hygiene. J other than "natural", or flems 23 event, the Medical Examiner may United States 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Waa Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian. Black, Whita, atc. filed within 72 hours after 1 ☐ Yas 2 ☑ No If Yes, Giva Year or Dates: 1 Nevar Married 2 Married 21215-0020 1 Yes 2 No Specify: þ 3√ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) College (1-4or 5+) 12 School Teacher Education Baitimore, Maryiand 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Heelth and Mental Edward Crisp Francis Wilson 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a If item 27 is or other tra Marilyn F. Stadler-Daughter 5605 Quincy Street, Hyattsville, Maryland 20784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition Data 1 Buriai 2 ☐ Cremation 3 ☐ Removal from Stata permit. Page Department of Important: If any Injury or 4 ☐ Donation 5 ☐ Othar (Specify) 7-21-99 Brentwood, Maryland Fort Lincoln Cemetery

22. Name and Address of Facility 21. Signature of Funaral Service Lice Fort Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, Maryland 20722 23a. Part1. Entar the disease, or domplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onset and Death **Physician** /Medical immediata Ceuse (Finai DISEASE LUNG CHRONIC 7628 disaasa or condition rasulting in death) Examiner Due to (or as a consequence of) Examiner icien and buriel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physicien Physician/Medical the Dua to (or as a consequence of): USB BS Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? á 1 Yes 2 No 3 Probably 4 Thknown be det þ 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of causa of death?

The lew requires that the death certificate be executed Box 68760. P.O. Division of Vital Records, page 2 or Attending Physician: funerel director, this To the Hospital or Attendir within 24 hours after death. To the Funeral Director: At

Completed Be filled in by

Certification: To edical

25. Was casa referred to medical

5 Pending investigation

6 ☐ Could not be

1 Yes 2 →No

27. Mannar of Death

1 Natural

2 Accident

3 Suicide

29a, Certifier

4 Homicida

Hospitai: 1 Inpatient

28a. Data of Injury (Month, Day Year)

completely

State Registrar

Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29b. Signature and life of continu 29c. License number 29d. Date signed (Month, Day, Year) of person who completed caylse of death (Item 23a) (Type, Print) ELMON 31. Data filed (Month, Day, Year) 32. Registrar'a Signatura

28c. Injury at Work?

1 Carriving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated
2 Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the

1 ☐ Yes 2 ☐ No

2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of Injury

28e. Place of trijury - At home, farm, street, factory, office building, etc. (Specify)

1 Yas 2 No

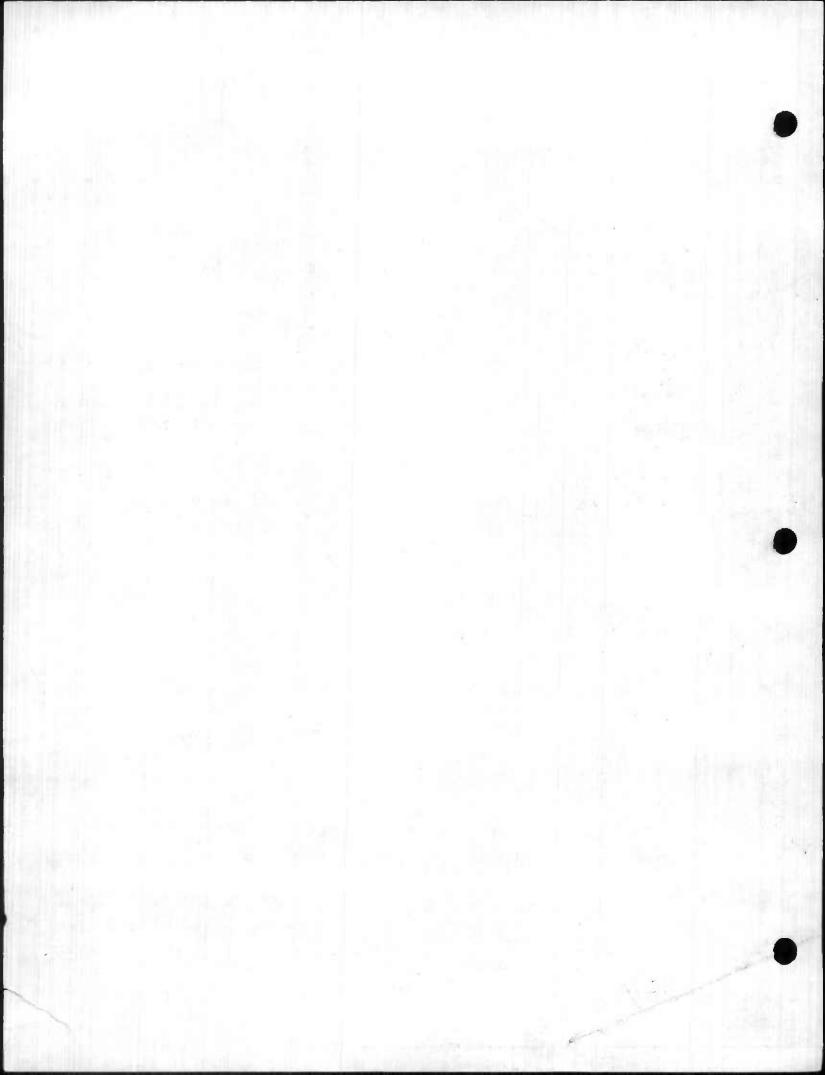
28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

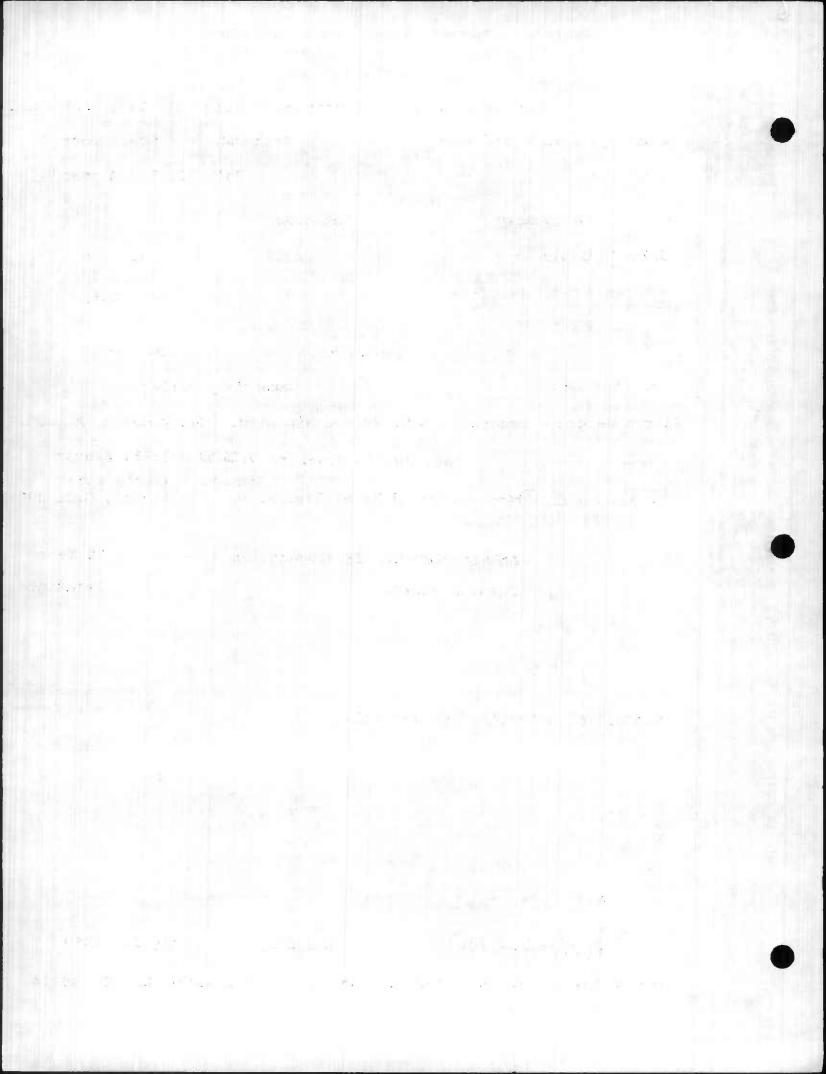
26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Rasidence 6 Other (Specify)

1 Yas 2 No



	Certificate of Death		Reg. No.	l o Time of Death							
Physician	1. Decedent's Name (First, Middle, Last)	2. Dete of Dea	Day Year								
/Medical	Elizabeth L. Franzmathes  4s Fecllity Nema (If not institution, give street and number)  4b. City, Tow	July	21 1999 4c. County of Dea								
Examiner		thesda	Monta								
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) If Under 1 Year If Under 2	4 Hrs. 8. Date of Birt		rthpiace (Stete or Foreign ountry)							
Director	509-09-4592 1 M 2 F 92 Yrs. Months Days Hours Usual Residence of Decedent		20,1907 K								
should be filled within 72 hours after death with the Maryland of Mental Hygiene.  marked other than "natural", or items 23s or 28s-f show immitic event, the Medical Examinat must be notified at To Be Completed by Funeral Director	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits							
	MD Montgomery Bethesda			1X Yes 2 No							
r items 23a or 25s-f al nove must be notified Funeral Director	10e. Street and Number 10f. Zip Code 2081		10g. Citizen of What C								
hems 2 Inst. mul	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Orig			arican Indian,							
at, or items 23a or 23a-1 sho Esantiner must be notified at by Funeral Director	Armed Forces?  1 Nevar Married 2 Married  1 Yes 2 No If Yes, Specify Cuban, Mexicen, 1 Yes, Sive 1 Yes, Specify Cuban, Mexicen, 1 Yes, Specify Cuban, Mexic	Puerto Rican, etc.)	Specify: W								
al Hygiene.  d other than "nature ovent, me we died!  Be Completed	15. Decedant's Education (Specify only highest grade completed) (Give kind of work done during most	of working	16b. Kind of Businass	s/Industry							
nan h	Elementary/Secondary (0-12) College (1-4or 5+)		0 77								
O O	17. Father's Nama (First, Middle, Last)  18. Mother	's Name (First, Middle,	Own Ho	me							
ed of		se Mary F									
marke matic	19a. Informant's Name/Raiationship (Type, Print)  19b. Mailing Address (Straat end Number			Zin Code)							
trau	George Daigre - Trustee 5550 Friendship		evy Chas								
tam other	20a. Method of Disposition  20b. Place of Disposition (Name of cametery, cremetory or other place)	Date	20c. Location - City o								
permit. Pages 1 and 2 should be filled within 72 hours between to the falls had Mental Hygiene. Important: If itam 27 is marked other than "natural", any injury or other traumatic event, the Medical Exapace.  To Be Completed by	4 Donetion 5 Other (Specify) St. John's Cemetery		Beloit,	Kansas							
	21. Signature of Funeral Service Licensee  22. Name and Address of Fecility  Thomas, E. Hornbaker 5130 WI Ave. 1	oosebu	Gawler's shington								
100	23a. Part1. Entar tha disaase, or complications that ceused tha daath. Do not antar tha mode of dying, such as a shock, or heart failure. List only one cause on each lina.	cerdiac or respiretory ar	rest,	Approximete intervai Between							
hysician				Onset and Death							
Medical aminer	immediate Cause (Final disease or condition a Atherosclerotic Cardiovaso	cular Dis	ease	20 Years							
	resulting in death)  Dua to (or as a consequence of):										
nlne	Cardiac Arrest			Immediate							
physician and is the burial-transit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  Due to (or as a consequence of):  Due to (or es a consequence of):										
	that initiated events resulting in daath) Lest  Due to (or es a consequence of):										
ate has been signed by the attending page 2 should be detached for use a Completed by Physician/M	d										
bed ched	Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.			te to the cause of death?							
detail detail	Asthma, Alzheimer's Type Dementia	10	1 Yes 2 No 3 Probably 4								
n signed ald be de		24a. Was	an autopsy 24b	. Were autopsy findings available prior to							
should should		perfo	rmed?	available prior to completion of ceuse of death?							
a has aga 2 omp		10	Yes 20 No	1 Yes 2 No							
certificata rector, pag	25. Was cese rafarrad to medicai 26. Place	of Daath (Check only of									
fer this ineral di	examinar? Hespital: Other:	rsing Home 5 Resid		ecify)							
	27. Mannar of Death 128. Data of injury (Month, Day Year)  28b. Time of injury work?  28c. Injury at Work?		how injury occurred								
	2 ☐ Accident Investigation M 1 ☐ Yes 2 ☐ N										
Direct Direct Jin by	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be datermined  28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)	28f. Location (: City or Tox	Street end Number or I vn, State)	Rural Route Number,							
within 24 hours after death.  To the Funeral Director: A completely filled in by the transmission of the funeral Certification of the func	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) and mannar as stated.										
Wed	one) and manner stated.  29b. Signature and fills of common 29c. License number		29d. Date signed (Mor	oth Day Year)							
D -	D 2657		July 23,								
	30. Name and address of person who convicted ceuse of death (Item 23a) (Type, Print)  Irving Mizus, M. D. 4930 Del Ray Ave.	#301 Bet	thesda. M	D 20814							
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature	,									
Registrar	1111 23 1999 Some B. Sparks										



State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Physic /Medi Exami	ical
Funeral Director	
end w	

permit. Pages 1 and 2 should be filed within 72 hours effer death with the Meryl. Department of Health and Mental Hygiera. Important: If flam 27 is marked other than "natural", or flams 23s or 28s-f sho and Injury or other traumstic avant, the Medical Examiner must be notified a one.

Physician /Medical Examiner

ettending physician and for use es the bunal-transit signed by certificate has After this

P.O. Box 68760,

Division of Vital Records,

requires that the death certificate be axec. To the Hospital or Attanding I within 24 hours after death.

To the Funeral Director: After

2. Data of Deeth 1. Decedani's Nama (First, Middle, Last) 3 Time of Death 2:24 AM Pedro Fuentes 4a Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Takoma Park Montgomery Washington Adventist Hospital If Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number 8. Data of Birth (Month, Day, Year) Feb. 9, 1955 9. Birthplaca (Stata or Foraign El Salvador 6. Sax 7. Aga (In yrs. last birthday) 1 M 2 F Months Days Hours Yrs. 44 460-99-7376 Usual Rasidance of Decedant 10e State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No Silver Spring Maryland Montgomery 10e. Streel and Number 10f. Zip Coda 10g. Citizen of What Country? 20901 15 Manchester Place, #101 El Salvador Funeral 12. Wes Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yes, Giva Yaar or Datas: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, White, atc. 1 Never Married 2 Married 1X Yas 2□ No Specify: El Salvadoran Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedant's Education (Specify only highast grade completed) 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Printing Company 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Sumama) Pedro Vialos Carman Fuentes 19a. Informant's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) 15 Manchester Place, #101, Silver Spring, MD 20901 Sandos I. Vasquez (friend) 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) San Salvador, 1 X Buriel 2 ☐ Crametion 3 ☐ Ramoval from Stata 7-28-99 El Salvador 4 ☐ Donation 5 ☐ Other (Specify) Jardines del Recuerdo 21. Signatura of Funaral Service Licanses 22. Name and Addrass of Facility
Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 20910 0 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiretory arrest, shock, or hear failure. List only one cause on each line. Approximeta Interval Batween Onset and Death Immediata Ceuse (Finel disaase or condition resulting in daeth) Examiner Sequentially list conditions, if any, laeding to immadiata causa. Enter Underlying Cause (Disease or injury that initiated avants rasulting in deeth) Lest Due to (or es e consaquence of): Physician/Medical Dua to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown mmyro depicien ρ 24b. Wara autopsy findings available prior to completion of causa of deeth? Completed 24a. Was an autopsy 1 TYas 2 No 25. Wes case refarred to medical axaminar? Be 26. Placa of Death (Check only one) 1 Yas 2 No Hospitel: Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 9 1 Inpatient 2 ER/Outpetient 3 DOA 28a. Deta of Injury (Month, Dey Year) 27. Manner of Deeth

1 Netural

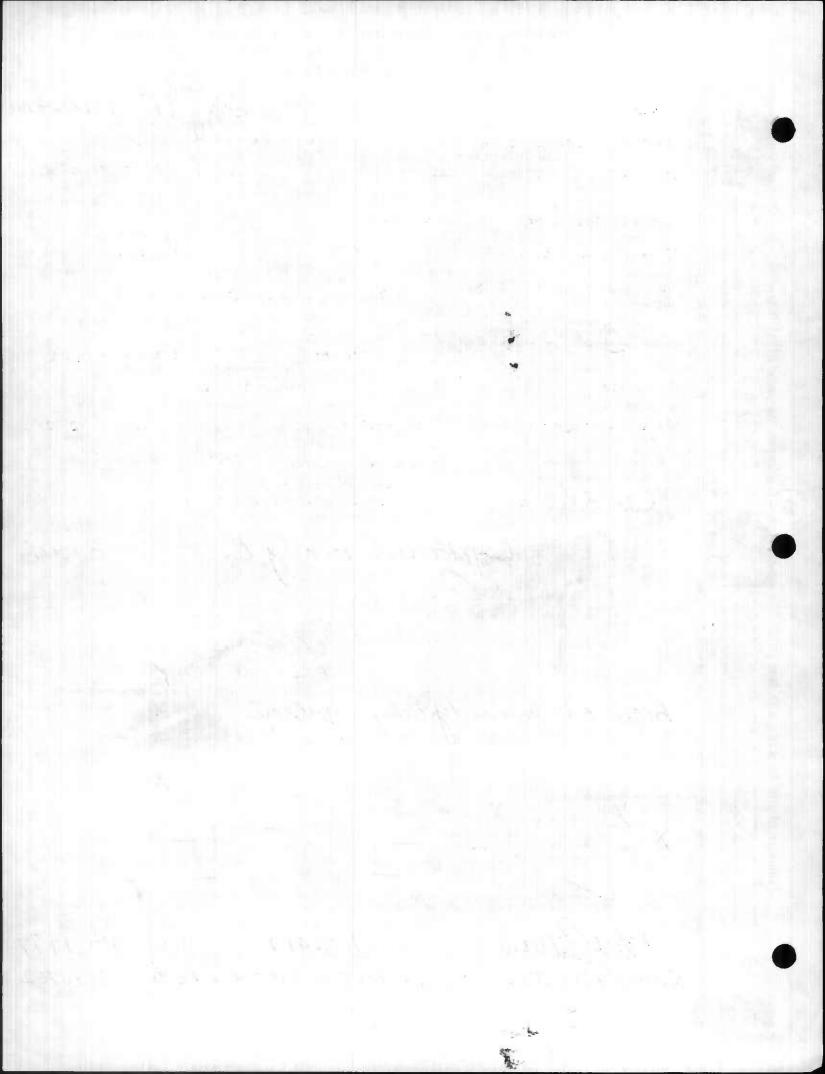
2 Accident 28c. Injury et Work? 28b. Tima of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Tas 2 No 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicide 29a. Cartifier Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, and due to the causa(s) end menner as stated. (Check only one) 2 Medical Examiner: On the basis of axaminetion and/or invastigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated. 29d. Dete signed (Month, Qay, Yaar) 29b. Signatura and titla of conflian 29c. Licansa number

State Registrar

31. Data filed (Month, Day, Year)

GEORGIA AVENUE Wheaton 12016 32. Ragistrar's Signatura

d causa of daeth (Item 23e) (Type, Print)



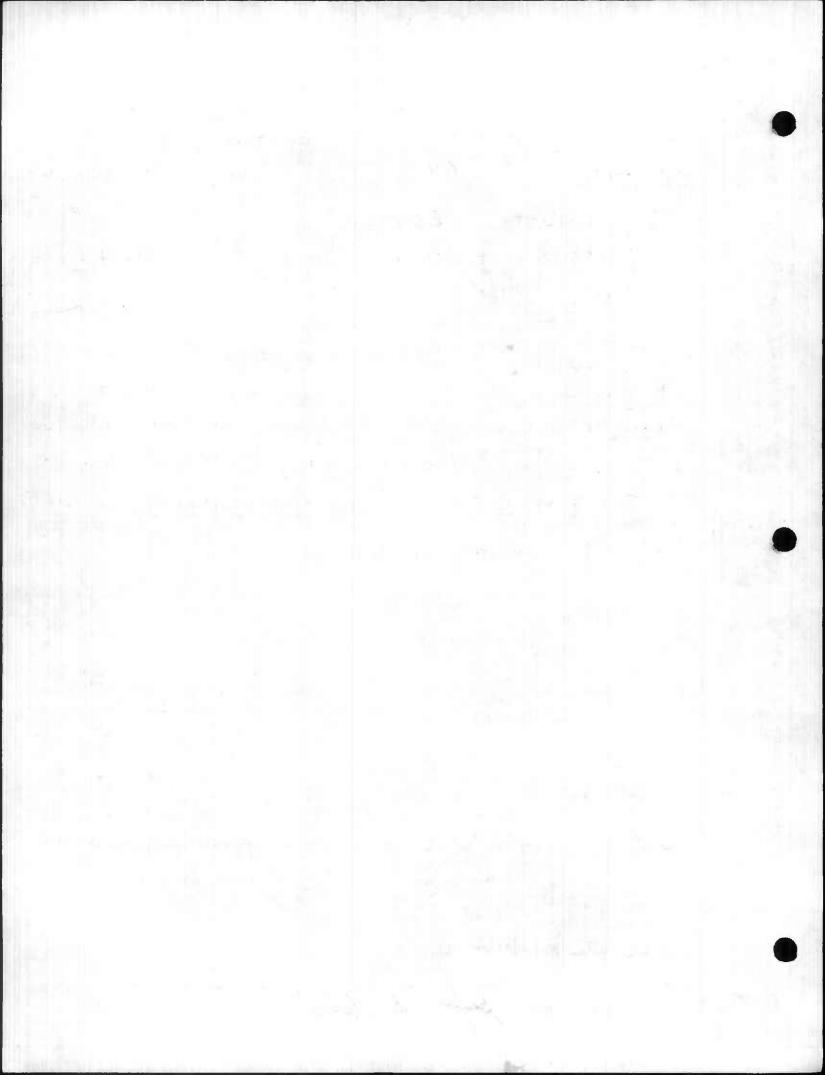
State of Maryland / Department of Health and Mental Hygiene 99 24330

ROSALIE FREEMAN
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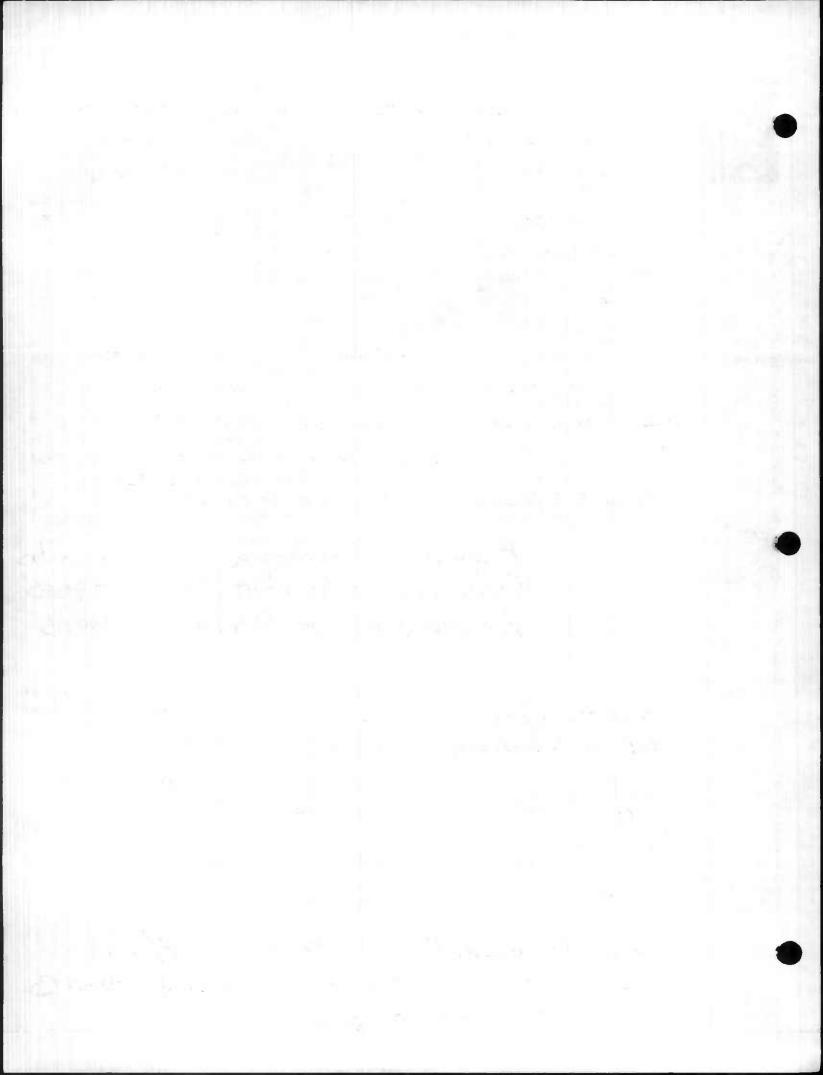
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4. Cury Town or Location of Death TALBOTT TALB	8			Rosalie	FRE	FREEMAN							2245 PM	
Function    Social Scientify Number   Social Scientify Number   Social Scientific Name   Social					street and number)									
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To Comment of Secretary Control of Secretary Contro				220-32-1616 1		11	Months			8. Date of B (Month, D	Year) 79 35	9. Birthplac Country	Ce (State or Forei	gn
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3   Widowed   1   Ves   2   Mode   1   Ves   2	2 8	15	ne		12. Wes Decedent Ever	r in U,S.	13. Was Dec	edent of	Hispanic Origin? (	Specify Yes or N	0- 14. Rac			
18. Mother's Name (First, Middle, Maiden Sumanne)   18. Mother's Nam	200	8			1 ☐ Yes 2 ☑ No If Yes, Give		0.0 / 0.00	1 1		, , , , , , , , , , , , , , , , , , , ,				
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18. Mother's Name (First, Middle, Maiden Sumanne)   18. Mother's Nam	212	Page 1	E C	Elementary/Secondary (0-12)	College (1-4or 5+)	A					Manage	Castu	2:10	
20. Method of Disposition 1½ Suries 2 Cremetion 3 Removel from Stete 4 Donellon 5 Other (Specify) 21. Signature of Funerer Service Licensee 22. Name and Address of Facility He N RY Funeral Home P.A. 23. Part the first eligibles, or complications that caused this beath. Do not enter the mode of dying, such as cardiac or respiratory errest.  23. Part the first eligibles, or complications that caused this beath. Do not enter the mode of dying, such as cardiac or respiratory errest.  23. Part the first eligibles, or complications that caused this beath. Do not enter the mode of dying, such as cardiac or respiratory errest.  23. Part the first eligibles, or complications that caused this beath. Do not enter the mode of dying, such as cardiac or respiratory errest.  23. Part the first eligibles, or complications that caused this beath. Do not enter the mode of dying, such as cardiac or respiratory errest.  23. Part the first eligibles, or complications that caused this beath. Do not enter the mode of dying, such as cardiac or respiratory errest.  25. August and the first eligible profit in first eligible profit eligibles and the first eligible profit eligibles are respiratory errest.  25. Due to (or as a consequence of):  25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. West case referred to medical examiner?  28. Was case referred to medical examiner?  29. Was case referred to medical examiner?  29. Was case referred to medical examiner?  29. Was case referred to medical examiner?  29. Was case referred to medical examiner?  29. Was case referred to medical examiner?  29. Was case referred to medical examiner?  29. Was case referred to medical examiner?  29. Was case referred to medical examiner?  29. Was case referred to medical examiner?  29. Was case referred to medical examiner?  29. Was case referred to medical examiner?  29. Was case referred to medical examiner?  29. Was case referred to medical examiner?  29. Was case referred to medical examiner?  29. Was case referred to	0	Hyg Bmf, 1		17. Father's Neme (First, Middle, Last)	I.	"	J JE/M DI	7 5					KING	
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25. Was case referred to medical examiner?  26. Place of Death (Check only one)  Hospitel: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence 6/13/Other (Specify) AT Si			0							11	Yes 2 No	181	es 2 No	
La Samuel Control of the second of the secon	/ita	otor,		examiner?						eath (Check only	one)	1		
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Accident   Suicide   Sui	0 E	ther	O.		niury						LUCAD			
28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)  29e. Certifier  29e. Certifier  1 Certifying Physician: To the basis of exemplacities and/or investigation in an exemplacities and place, and due to the cause(s) and manner as stated.	Sio	for: A	cati	28 Accident investigation 7 14 99 22:33 P										
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29b. Signafure and title of certifier (Month, Day, Year)	othe	o the		29b. Signature and title of certifier	4/		2	9c. Licen	se number		29d. Date signe	d (Month, Da	ly, Year)	
O.C.M.E JULY 15, 1999		s == 0		DUNIT. OF	n Unile	NIM		0.	C.M.E		JULY 1	5, 199	9	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			-	30. Name and address of person who	completed cause of death	(Item 23a)	(Type, Print)							
11001.00 200 1 1/000				yorky Druts	1. KONSU			- 1	Baltimo		.1 2 21	201		

State Registrar

31. Date filed (Month, Day, Year)
JUL 1 9 1999



					viaiyiaik		tificate of		Mental Hygi	g. No.	9 2	4331
-	Physic	an	Decedent's Neme (First, Middle						Dete of Deeth     Month	Dey	Yeer	3. Time of Death
d	/Medi	ai	4e. Fecility Neme (If not Institution,	HUGH	4b. City, Town, or I	July 1			12:35 am			
٧	Examir	ier		beake Woods		er		Cambri		4c. County of Deeth Dorchester		
	Funeral Director		5. Social Security Number 215–20–0265		Age (In yrs. la 74		If Under 1 Yeer Months Deys	If Under 24 Hrs. Houra Min.	_			lece (Stete or Foreign
	pu k.		Uauel Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation				1	0d. Inside City Limita
L	Maryl Fatho	lor	20 200	nester			mbridge				1.	1 ☐ Yes 2 No
1	2 m 2 m 2 m 2 m 2 m 2 m 2 m 2 m 2 m 2 m	Director	10e. Street end Number				10f. Zip Code		10	g. Citizen of	Whet Coun	try?
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Maryland 21215-0020	ours after der alf, or items Examiner m	by Funeral	11. Marital Stetus  1 Never Merried 2 Marrie 3 Widowed 4 Divorced	12. Was Deceder Armed Force 1  Yes 2 If Yes, Give Year or Deter	s? No	If	Vas Decedent of Hi Yes, specify Cube	lispenic Origin? (S en, Mexican, Puerti Specify:	pecify Yes or No- p Rican, etc.)		e - Americok, White, o	
5-0	72 hz Trattur dical	eted	15. Decedent' (Specify only highest	s Education grede completed)		16e. Deced	lent's Usuel Occup	netion during most of world)	kina 1	6b. Kind of B	usiness/Inc	duatry
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d 2	filed Hygin other ant, II		17. Fether's Name (First, Middle, L	ast)		Ca	rpenter	18. Mother's Nen	ne (First, Middle, M			1011
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lan	and A and A is ma		19e. Informent's Neme/Reletionsh	ip (Type, Print)		19b. Meilin	g Address (Street	end Number or Ru	rel Route Number,	City or Town,	Stete, Zip	Code)
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altimore,	lages I int of H t: If the y or off		20e. Method of Disposition  120 Burial 2 Cremetion				sition (Neme of netory or other plea			Oc. Location		
altir	artme ortan Injury		4 ☐ Donetion 5 ☐ Other (Sp. 21. Signeture of Funeral Service L		1001		. Name end Addre	ial Park ss of Fecility π				Maryland
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	- 3		23a. Pert1. Enter the disease, or c shock, or heart feilure. List o	complications that caus	ed the death.							Approximete Intervel Between
	Physician /Medical Examiner		Immediate Ceuse (Finel disease or condition resulting in death)	e. As	PICA	+10 y	1 Pre	vmon	4		o	Onset and Death Pueeks
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Box	death certif e ettending ed for use e	lan		d								
o.	the d	Physician/M	Pert II. Other significant condition	-		lting in the ur	derlying cause giv	en in Pert I.	23b. Did tob	acco use co	ntributa to	the cause of death?
۵		by Ph	Hyperter	15100					1 □ Ye	2) ZNO	3 Prot	ably 4 ☐ Unknown
Records,	requir seen s should	Completed b	Hypercho	lesterolen	sterolenia					eutopsy ed?	ave	are eutopsy findings pilable prior to appletion of cause death?
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on	ding h. After fune	tlon	1 Naturel 5 Pending		ley Year)	28b. Time of Injury	28c. Injur Wor	yet k? Yes 2 □ No	28d. Describe how	w injury occur	red	
Division	Attending in death.	Certification:	2 Accident Investige 3 Suicide 6 Could no 4 Homicide determin	ot be 28e. Placa of I	njury - At hor	ne, ferm, stre	eet, fectory, office	100 2 110	28f. Location (Stre	eet end Numb	er or Rure	Route Number,
Ö	its of it	Cert	4   Notificide	building,	etc. (Specity)	, 			City or Town,	51010)		
	To the Hospital or Attending Physician: within 24 hours efter death.  To the Funeral Director: After this certific completely filled in by the funeral director,	edical	29e. Certifier 1 Certifying (Check only one)	Physician: To the bes xaminer: On the basis end menner:	of exeminetic	rledge, deeth on end/or inv	occurred et the tin estigation, in my o	ne, dete end pleca pinion, deeth occur	end due to the ceu red et the time, det	use(s) and me te and plece,	enner as st end due to	ated. the cause(s)
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•			" Eligne /	Munai	10/	4440	run HS	1143		1/1	7/8	4
			30. Name end address of person w	ho completed ceuse of	deeth (Item :	23e) (Type, F	Print)	n C+	Cal	1	MA	2/613
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DH	IMH 16 Rav 6/9!						1					



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month July 19, 1999 11:05pm Helen M. Garrity 4b. City. Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Takoma Park Montgomery Sligo Creek Nursing Center if Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dale of Birth (Month, Dev. Year) 1 ☐ M 2 🖾 F Days Hours Yrs 032-07-8118 July 10, 1918 Massachussetts Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. inside City Limits 1 Yes 2 No Virginia Fairfax Annandale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22003 USA 4005 Estabrook Drive 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Giva Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White 1 Yes 2 No Specify: 3 N Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Fashion/Retail Manager 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) James N. O'Shaughnessy Mary Brogan 19b. Malling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4005 Estabrook Drive, Annandale, VA 22003 Diane C. Garrity/ Daughter 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition Date July 24 Burial 2 Cremation 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven 1999 Silver Spring, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 23a. Part Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each lie. 500 University Blvd. W, Silver Spring, MD 20901 Approximate interval Between Onset and Death Immediate Ceuse (Finel disease or condition resulting in death) ACUTE ASSIRATION NEUROGENIC OYSI HOTA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Donavira 23b. Did tobacco use contribute to the cause of death? Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Wera autopsy findings available prior to completion of cause of death? 26. Place of Death (Check only one)

**Physician** /Medical **Examiner** requires that the death certificate be executed

**Physician** 

/Medical

Examiner

Directo

Funeral

p

Completed

**Funeral** 

**Director** 

the Manylend

permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylen Department of Health and Mental Hygiene.
Important: If itam 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Expression and be involted an enter.

Baltimore, Maryland 21215-0020

Examine physician end the burial-transit Physician/Medical 88 980 signed by the e by Completed been page 2 hes certificate Be To this Certification:

funeral Affer deeth. s efter deet! 24 hours efter dec Ne Funeral Director oletely filled in by th

Division of Vital Records, P.O. Box 68760,

Attending Physician:

25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 8 Other (Specify) Yes 2□ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? Matural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28d. Describe how injury occurred 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Sign and lille of certifier 29c. License number

29d. Date signed (Month, Day, Year) JULY 23, 1994

30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)

11/25 Pocities Pict, Pockille, no 7089 I. MARGOUD, MO

State Registrar

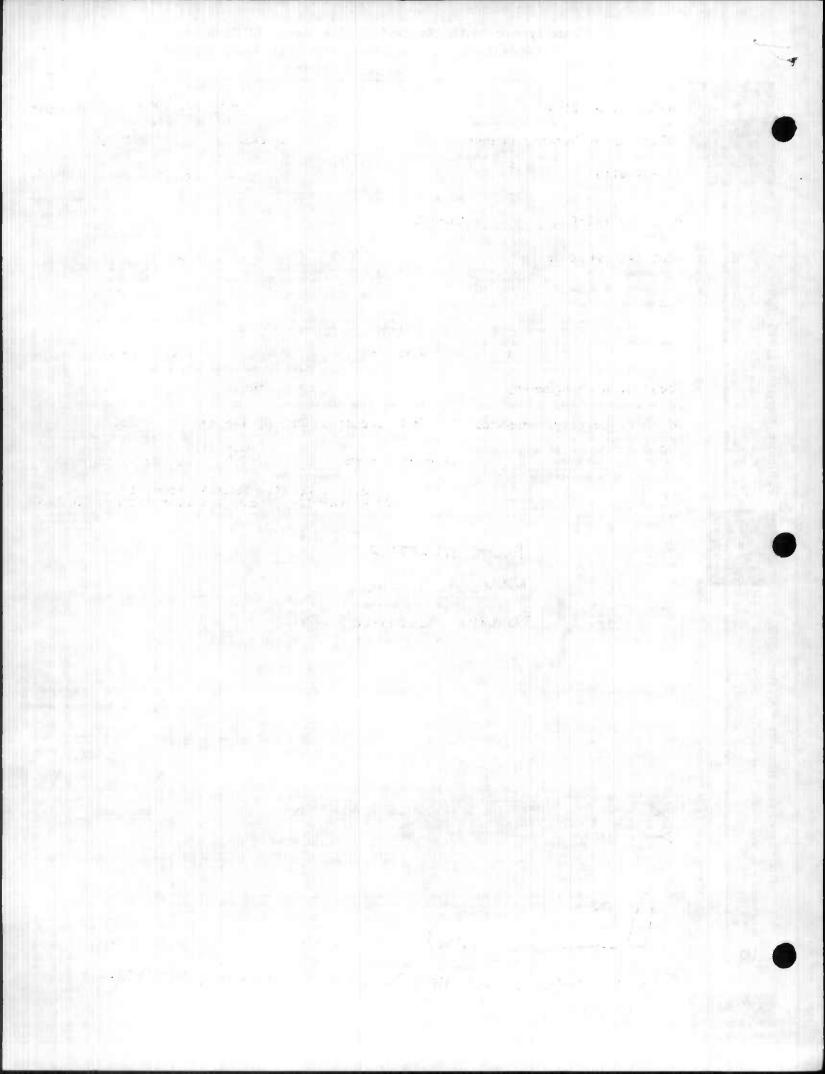
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31. Date filed (Month, Dey, Yeer) 2 3 1999 JUL

32. Registrar's Signature

To the Hosp within 24 hor To the Fune completely fi

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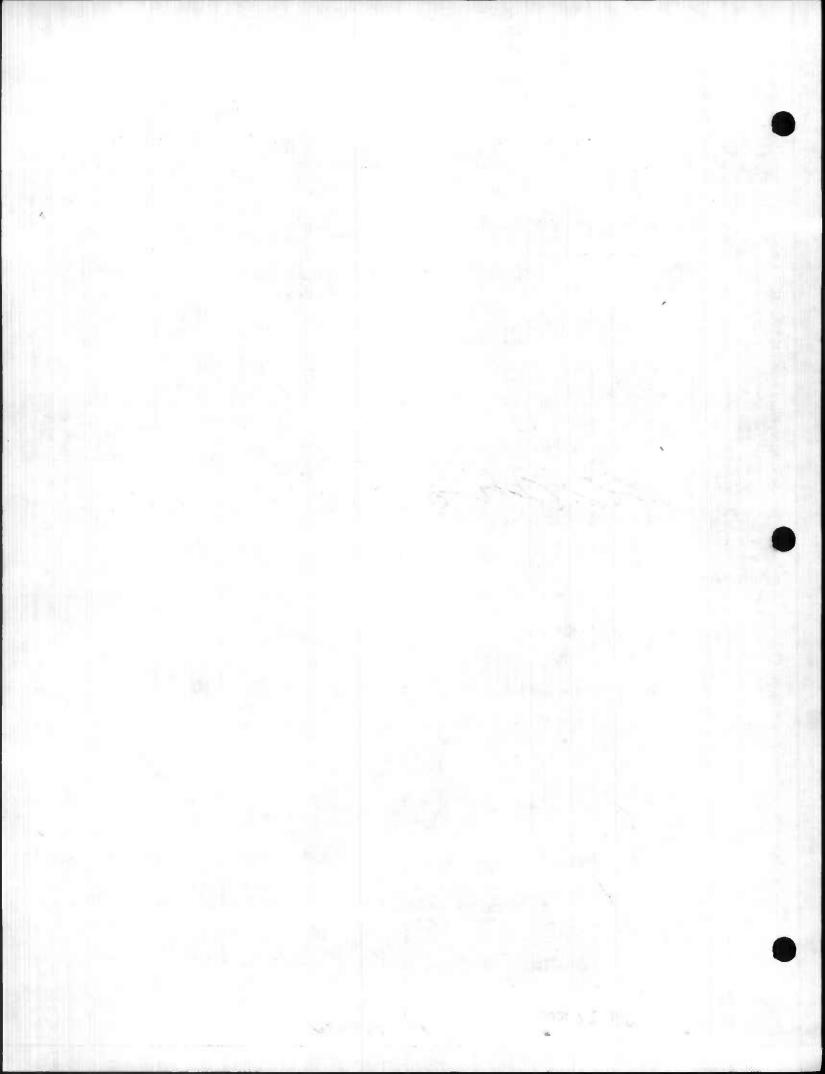


State of Maryland / Department of Health and Mental Hygiene AMEND# 20B, 20C 7/19/99 CMH AACO HEALTH Certificate of Death 1. Decedent'a Nema (First, Middle, Last) 2. Data of Death 3. Tima of Death Dev Month **Physician** July 11, 1999 C. Marie Gent 6:08AM /Medical 4e Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel ff Under 1 Yeer | If Under 24 Hra. | 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1□M 2□F Yrs. **Director** 059-18-3208 78 Oct.12, 1920 Virginia Usual Rasidence of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits show 1 ☐ Yas 2 No Directo 28a-f Maryland Anne Arundel Edgewater 10e. Street and Number 10f. Zio Code 10g. Citizan of What Country? items 23s or 400 Londontown Road 21037 USA Funeral 12. Was Decedant Ever In U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: 13. Waa Decedent of Hispenic Origin? (Specify Yes or No-lf Yas, specify Cuben, Maxican, Puarto Rican, atc.) 14. Reca - Amarican Indian, Bleck, Whita, atc. 11. Maritel Stetus filed within 72 hours after 1 Nevar Married 2 Married 8 altimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: Specify: White 3 ₩Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grade completed) Hyglene. Elamentary/Secondary (0-12) Collega (1-4or 5+) Homemaker Home 17. Father's Nema (First, Middle, Last) 18. Mothar's Nama (First, Middle, Meiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Nem 27 is marked or any Injury or other traumatic eve Aleph H. Wood Beaulah Drumheller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Gent/Son 400 Londontown Road Edgewater, Maryland 21037 20h Piace of Disposition (Name of 20a. Mathod of Disposition Date 20c. Location - City or Town, Stata HILLCREST MEMORIAL GARDENS Lakemont Memil: Cardens 7-14-99 ANNAPOLIS, MD Davidsonville, Mo 1 Buriat 2 □ Cramation 3 □ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signatura of Funeral Service Lice 22. Nama and Addrass of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, Md. 23a. Part1. Entar tha disaasa, or complications that caused the death. Do not entar the mode of dying, such as cardiec or respiratory arrest, Appr. shock, or heart failure. List only one cause on each line. 21037 Approximate Interval Between Onset and Deeth **Physician** /Medical Immediata Causa (Finat Resp Former disaase or condition resulting in death) Examiner Myscadic ( DAMER Examiner physician and the burial-transit Sequentially list conditions, if any, taeding to immadiata cause. Enter Underlying Causa (Disasse or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of) Box 68760 Physician/Medical Dua to (or as a consequence of): P.O. Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown TYPERTENJEON Records, þ 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy FURTIC STRADING complation of cause of death? 1 Yas 2 No 1 ☐ Yas 2 ☐ No Division of Vital 25. Was casa rafarred to medical axaminar? Be 26. Placa of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 DER/Outpatient 3 ☐ DOA 1 Yas 2 No Other: 4 Nursing Homa 5 Rasidanca 8 Othar (Specify) Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred After 5 Panding Investigation or Attending 24 hours after death.

Funeral Director: After the function of 1 Yas 2 No 2 Accidant 6 Could not be datarmined 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Sulcida 28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Phyatclan: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and mannar as stated.

2 Medical Examiner: On the best of axamination and/or invastigation, in my opinion, death occurred et the time, data and place, and due to the cause(s) and mannar stated. Medical 29a. Cartifie To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signature end title of certifier 29c. Licanse number 29d. Data aigned (Month, Day, Year) D0355 12. 30. Nama and addrass of person who completed causa of daath (Item 23a) (Type, Print) ROBERT M. GREENFIELD M.D. 139 OLD SOLOMONS ISLAND ROAD ANNAPOLIS, MD. 21401 31. Data filed (Month, Day, Year) 32. Registrer's Signature State Registrar 1 4 1999

DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** July 9, 1999 12:10 P.M. Odessa W. Greene /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Anne Arundel 803 Coxswain Way #101 Annapolis If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) Birthpiece (State or Foreign Country) **Funeral** 1□M 21 F Days 74 Yrs. 1925 Kentucky Director 404-28-3640 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21401 USA 803 Coxswain Way #101 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22 DNo if Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 Never Merried 2 Married 1□ Yes 2□No þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Home 12th 17. Fether'e Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Martha Napier Hiram Wooten 2 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 803 Coxswain Way #101 Annapolis, Maryland 21401 Fred A. Greene, Jr./ Husband 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriei 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Doneţion 5 ☐ Other (Specify) Lakemont Mem'1. Gardens 7-12-99 Davidsonville, MD 22. Name end Address of Fecility George P. Kalas Funeral Home 297.3 Solomons Island Rd. Edgewater, shock, or heert failure. List only one cause on each line. MD 21037 Approximete Intervei Between Onset end Death **Physician** Immediete Ceuse (Final disease or condition resulting in deeth) /Medical a. Respiratory Failure
Due to (or es e consequence of): Examiner Examiner Interstitial Pulmonary Fibrosis Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Lest Physician/Medical Due to (or es e consequence of) Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings aveilable prior to completion of ceuse of deeth? Completed 24a. Was an eutopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? Be 26. Piece of Death (Check only one) Hospitel: Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 1 Yes 2 No 7 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28e. Dete of injury (Month, Dey Year) 28c. Injury et Work? Certification: 1 Naturai 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the ceuse(s) end menner es stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier 30. Name and address of person who completed cause (Teath (Item 23a) (Type, Print) D12015

6492 Landover Rd, Landover, MD 20785

State Registrar -ouis

31. Dete filed (Month, Day, Year)

Steinberg

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32 Registrar's Signeture

the Maryland

permit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Manyian Department of Health and Mental Hygione. Important: if item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, the Modical Examiner man be notified as any injury or other traumatic event, the Modical Examiner man be notified as

physician end the burial-transit

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signed by

has

funeral

filled in by

To the Hospital or Attending Phys within 24 hours after deeth. To the Funeral Director: After this:

Box 68760. certificate be

P.O.

Division of Vital Records.

Baltimore, Maryland 21215-0020

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Deta of Death Month 3. Time of Death **Physician** July 6, Alexis Victoria Garcia-Jimenez 1999 12:34 A.M. /Medical 4e Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** University of Maryland Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) **Funeral** Days 10 M 20 F Months Hours Yrs. 0 July 3, 1999 Director Maryland Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at 1 Yes 2 No Maryland Charles Waldorf 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 급 flams 23a 6125 Gray Wolf Court 20603 USA Funeral 12. Wes Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. 1 Never Merried 2 Merried altimore, Maryland 21215-0020 'natural', or 1 1 Yes 2 □ No Specify: Ecuadorean Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) N/A N/A permit. Peges 1 and 2 should be file.
Department of Health and Mental Hy important: If fleen 27 is marked offin any Injury or other. 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fathar's Nama (First, Middla, Last) Be John David Jimenez Renee Elizabeth Garcia 20 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John D. Jimenez/ Father 6125 Gray Wolf Court Waldorf, Maryland 20603 20b. Pleca of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 M Burial 2 □ Cramation 3 □ Removel from State Lakemont Mem'1. Gardens 7-9-99 Davidsonville, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Guneral Se George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Părt1. Enter tha disaase, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiratory arrast, shock, or heert failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Finel Respiratory Failure diseese or condition resulting in death) Examiner Due to (or as a consequence of): Examiner The law requires that the death certificate be executed s the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequenca of): P.O. Box 68760. Physician/Medical Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 1 Yee 2 No 3 Probably 4 ♥ Unknown signed t Renal Failure Records, þ 24b. Were autopsy findings available prior to Completed 24a. Wes an autopsy Extreme Prematurity completion of cause of death? 1√ Yes 2□ No 1 Yes 2√ No Pulmonary Hemorrhage of Vital To the Hospital or Attending Physician: within 24 hours after death.

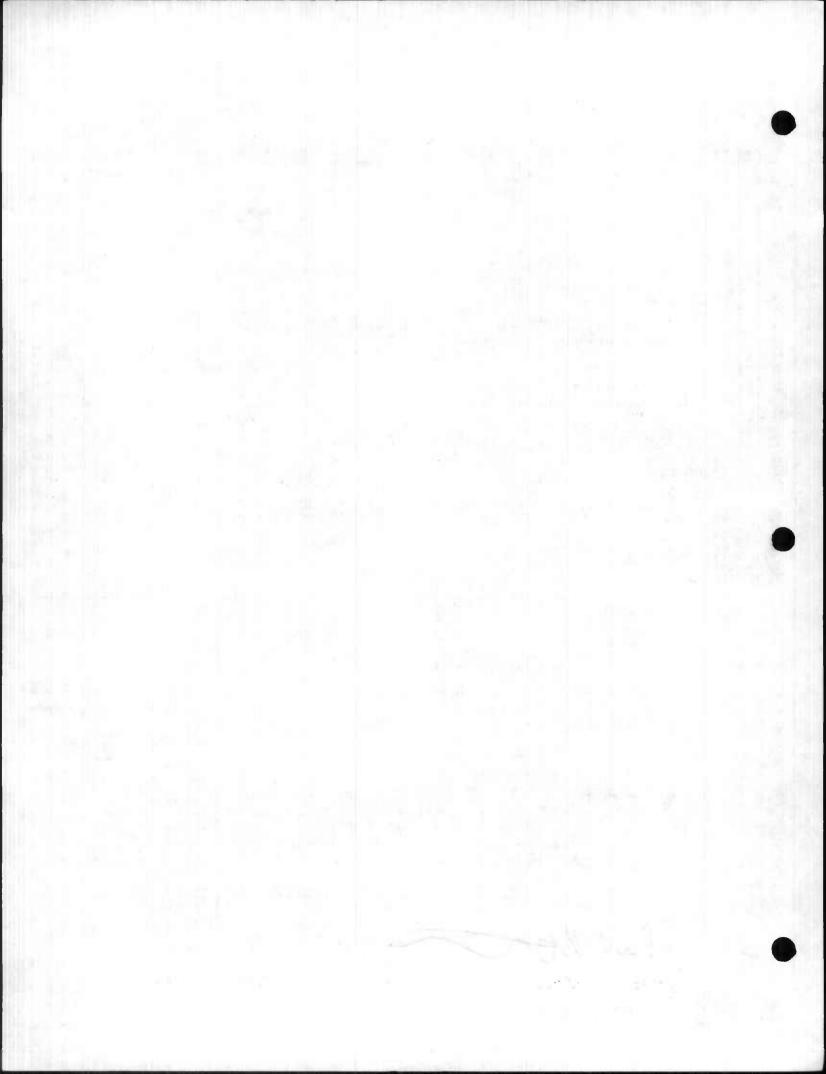
To the Funeral Director: After this certifica completely filled in by the funeral director, I Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 28d. Describe how Injury occurred 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? Certification: Division 1 (XNetural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Pieca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) end menner stated. Medical (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0051310 July 6, 1999 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) M.D. 22 S. Greene Street Baltimore, Maryland 21201 Misbah A. Qureshi 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State

Registrar **DHMH 16 Rev 6/95** 

State of Maryland / Department of Health and Mental Hygiene 99 21,336

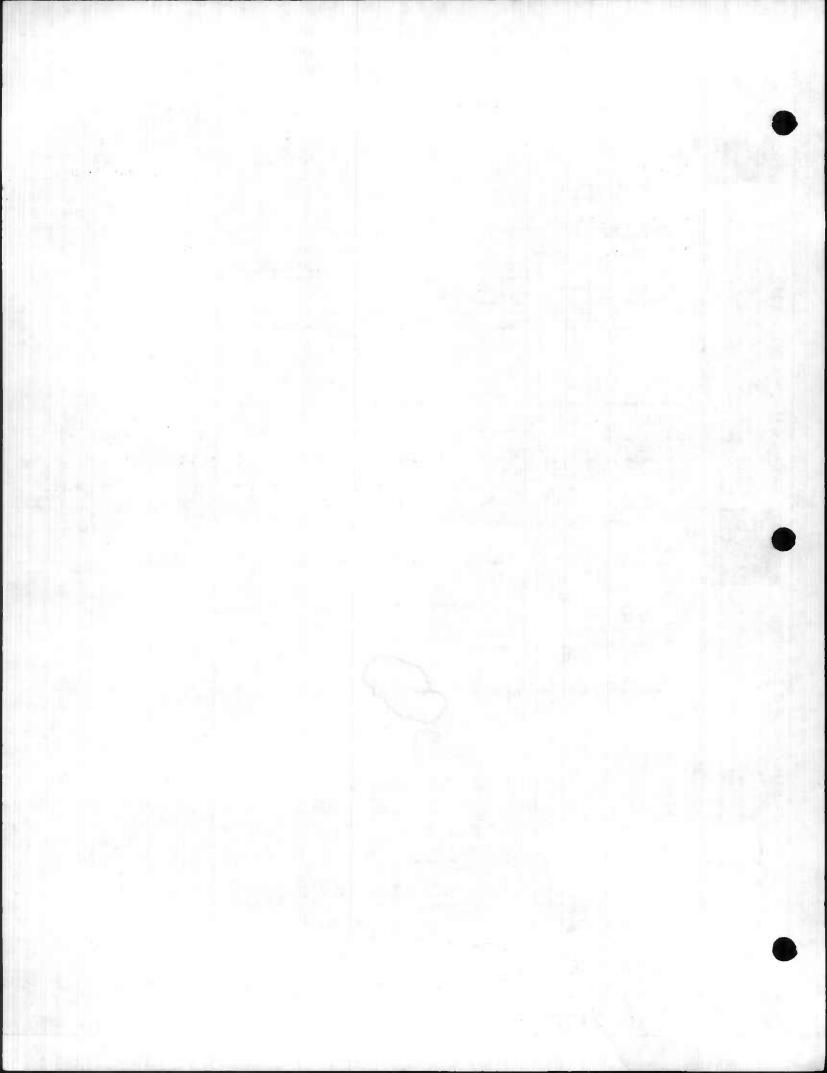
				C	ertifica	te of	Death			Reg. No.	00	Em "	000	
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Ruby F	uller	Garı	ner						Month July 2	Day 19	999 Year		10 PM	
iner 4a Facility Name (If not in	stitution, give	street and number	er)				4b. City, Tov	wn, or Loca	ation of Death		County of De			
	Holy Cross Rehabilitation & Nursing Center Burtonsville									Montgomery				
5. Social Security Number	6. Se	x 7.	Age (In yrs.		(v) If Und	er 1 Year			B. Date of Bir	th			State or Foreign	
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10a. Stata 10b. County 10c. City, Town or Location												10d. Ins	ide City Limits	
Maryland Mo	ontgome	rv	Sil	ver S	Spring							10	Yes 2 No	
10e. Street and Number	711 <b>0</b> 501110	J			-	ip Code			T	10a. Citiza	en of What C	Country?		
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2201 Colston 11. Merital Status 1 Never Merried 2		12. Was Deceder Armed Force		,S. 1	3. Was Dec	edent of I	Hispanic Orig	gin? (Speci	fy Yes or No	- 14	4. Race - An Black, Wh		an,	
1 ☐ Never Merried 2( 3 ☑ Widowed 4 ☐ Di		1 ☐ Yes 2 ☐ If Yes, Give Year or Date:	No			-	Specity:			5	Consider	hite		
15. D	ecedent's Edu			16a. De	cedent's Us	ual Occu	pation			16b. Kin	d of Busines	s/Industry		
(Specify only	highest grad		- Fal	(Gi	ve kind of w	ork done use retire	during most	of working						
15. Do (Specify only Elementary/Secondary ( 12	(0-12)	College (1-4d	N 3+)		Home	emake	er			Own	Home			
17. Father's Name (First, I	Middle, Last)			1.			_	r's Name (	First, Middle,	Maiden S	Sumame)			
John P. Ful	ler						Bess	ie La	ckey					
19a. Informant's Neme/Re		roe. Print)		19b M	ailing Arkfred	ss (Stree	t and Number			er, City or	Town, State	Zip Codel		
Bettie G. P			)				Avenue						0895	
20a. Method of Disposition		uaugiitel			position (N	-	ivellue	-	Date		ation - City o			
1 X Burial 2 Crem 4 Donation 5 0	nation 3 DF		10	cemetery, o	rematory or	other pla	l Park		-23-99					
21. Signature of Funeral S	ervice Licens	00			22. Name 8	nd Addre	ess of Facility	y	D D	Λ.				
10000	00	0.0					Avenue				Manu	-T-nd	20010	
23a. Pert1. Enter the dise	ase, or compl	ications that caus	ed the deat								, mary	Appro	ximete	
shock, or heart tailur	e. List only o	ne cause on each	line.									Interv	el Between and Death	
Immediate Cause (Finel														
disease or condition resulting in death)	lisease or condition Pneumonia esulting in death)												onth	
			Due to (d	or as a con	sequence of	):						1		
Sequentially list conditions if any, leading to immedia		b										i		
Sequentially list conditions if any, leading to immedial cause. Enter Underlying	s, te	Due to (or es a consequence of):												
cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	<	C	(or as a consequence of):											
resulting in death) Last					- 4-0.100 01	,								
<b>E</b>		d										1		
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-												of death?		
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25. Was case referred to r axaminer?	7000	to an inch				1.			Check only o					
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27. Manner of Death	Pending	28a. Date of Ir (Month, I	njury Day Year)	28b. Time Injur		28c. Inju Wo	iry at	28	d. Describe	how injury	occurred			
2 Accident	investigation		,,	2.95	М		Yes 2□N	No						
3 ☐ Suicide 6 ☐ 4 ☐ Hornicide	Could not be determined	28e. Place of building,	Injury - At h etc. (Specif	ome, tarm,	street, tacto	ry, office		28	f. Location ( City or To		Number or	Rural Route	e Number,	
29e. Certifier 1 C C (Check only 2 M		sician: To the bes											nuse(s)	
- A		end manner												
E 29b. Signature and title of	certified	_		_	2	9c. Licen	se number				signed (Mo	-	ear)	
D43237 July 22, 1999										999				
30. Name and address of p	person who co	empleted cause of	f death (Iter	n 23a) (Tvr	e, Print)									
Paul Armstro						rive	, #102	Lau	urel.	Marv1	land	20707		
31. Dete tiled (Month, Day			strer's Signe					,	,					
	8 100		الموادرة											



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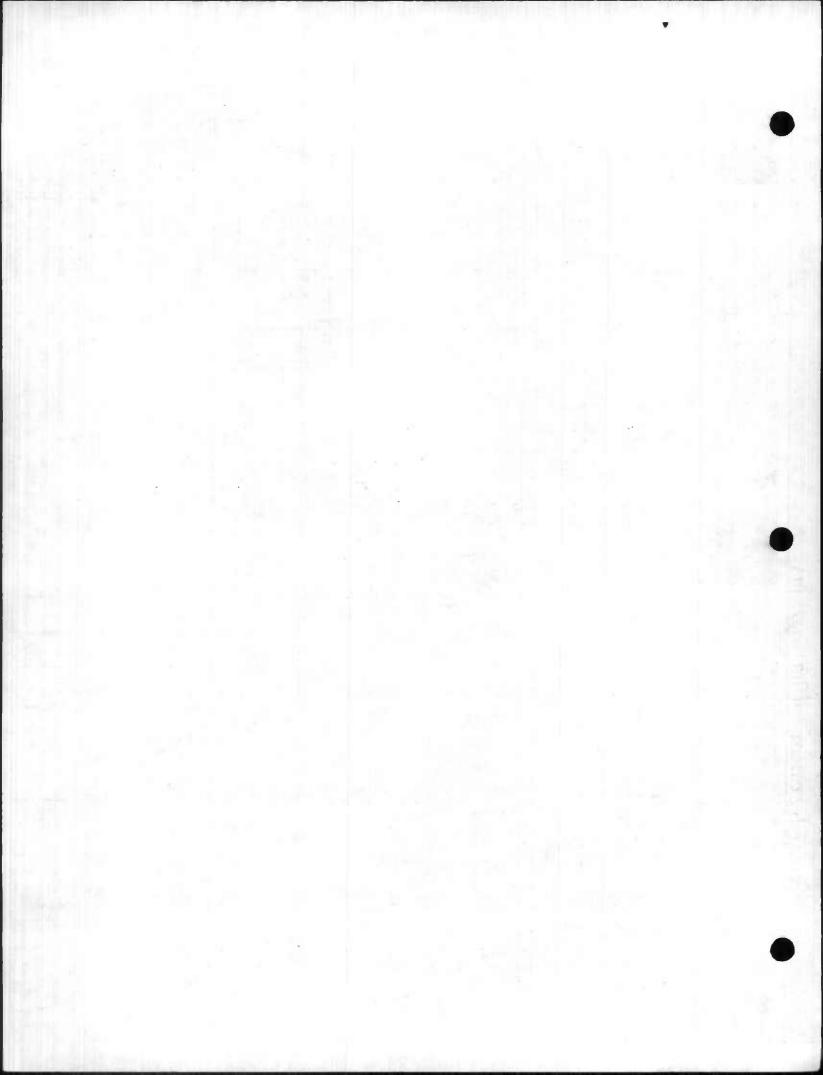
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	1. Decedent's Neme (First, Middle, L.	est)							2. Date of De Month		Vees	3. Tim	e of Death
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	4a Facility Name (If not institution, gi	ve street and numb	per)				4b. City, To	wn, or Lo	cation of Deat	-	ty of Death	1	
	3302 Tidewater	Court					Olney	7		Mont	gomer	y	
5	5. Social Security Number 6.	Sex 7.	Age (In yrs.	last birthday			If Under	24 Hrs.	8. Dete of Bir (Month, De		0	2	te or Foreign
	577-76-5539 Usual Residence of Decedent	1□ M 2以F	56	Yrs.	Months	Deys	Hours	Min.	May 24			ailan	
	10a. State 10b. County		10c. Cit	ty, Town or L	ocation							10d. Insid	e City Limits
Maryland Montgomery Olney  10e. Street and Number 10f. Zip Code 10g. Citizen of Wh												Yes 2 No	
	10e. Street and Number   10f. Zip Code   10g. Citizen of What Co   3302 Tidewater Court   20832   United Star											-	
- 2	11. Merital Status	12. Was Decede	ent Ever in U	I,S. 13.	Wes Dece	dent of h	lispanic Or	igin? (Spe	ecify Yes or No		ce - Ameri		n,
	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Force 1 Yes 2 If Yes, Give Year or Date	⊠ No				Specify:		Rican, etc.)	Spec	eck, White, ity: Tha		
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-	12	4).			С	ler		ld. et	Affirma Balan	1 1	shop		
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	19a. Informant's Neme/Relationship Frank K. Garnier		nd)							er, City or Tow Marylai		0832	
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ŀ	1 ☐ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Speci		ate	hesape				17	-19-99	9-99 Beltsville, Maryland			
-	21, Signature of Funeral Service Lice	*	- 01	-	2. Name er				10 00	DCICSV	1110,	IIGI.	y zuma
Г	10000	200		Rapp Funeral Services, P.A.									
1	Carol	Lieu	~							pring,	Maryl		20910
	23a. Part1. Enter the disease, or con shock, or heart failure. List only	one cause on eec	th line.	n. Do not en	iter the mod	de of dyli	ng, such es	cardiac	or respiretory a	irrest,	1	Approxi Intervel	Between and Death
	Immediate Course (Fine)										1	CHISOLO	NIG DOBUT
ı	Immediate Cause (Finat disease or condition resulting in death)  a METASTATIC CERVICAL CARCINOMA 2 years											ears	
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	25. Was case referred to medical examiner?  1   Yes   2   No    27. Manner of Death  1   Natural	Hospital: 1 Inp  28a. Date of Month,  28e. Place of building	Due to (c  Due to (c  Due to (c  Injury Day Year)  Injury - At h., etc. (Specification of examina	ER/Outpatie 28b. Time of Injury owne, ferm, st	quence of):  quence of):  underlying of  M  underlying of  M  underlying of  A  underlying of  29	Cause given and the control of the c	26. Place  26. Place  Ty at rk?  Yes 2   me, dete eropinion, decesse number	e of Deeti	24a. Wes performed to the conty or To end due to the	Yes 2 No sen autopsy primed?  Yes 2 No No one) idence 6 Oo how injury occ  (Street and Nur win, State)  cause(s) and idea and place  29d. Date sign	24b. We come a company of their (Specurred annument as a, and due and (Month)	Vere eutopebbly  Vere eutopebbly  Vere eutopebble pompletion of death?	4 ☐ Unknown  by findings  fior to  of cause  2 ☑ No  Number,
	25. Was case referred to medical examiner?  1   Yes   2   No    27. Manner of Death  1     Naturat   2   Accident   3   Suicide   4   Homicide    29a. Certifier (Check only one)    29b. Signature and title of certifier    20a. (Dispass or injury that initiated events resulting in death) Last  26. Was case referred to medical examiner?  1   Yes   2   No    27. Manner of Death   28. Certifier (Check only one)    29b. Signature and title of certifier    29c. Signature and title of certifier    29c. Signature and title of certifier    29c. Signature and title of certifier    29c. Signature and title of certifier    29c. Signature and title of certifier    29c. Signature and title of certifier	Hospital: 1 Inp 28a. Date of (Month, b) 28e. Place of building hysician: To the beminer: On the basis and manner	Due to (c  Due to (c  Due to (c  Due to (c)  Injury Day Year)  Injury - At h., etc. (Specili est of my knows of examinar stated.	EFVOutpatie 28b. Time of Injury ome, ferm, st	quence of):  quenc	OA Otto	26. Place  26. Place  Ty at rk?  Yes 2   me, dete eropinion, decesse number	e of Deeti	24a. Wes performed to the conty or To end due to the	Yes 2 No No nee)  Yes 2 No No nee)  Idence 6 O new injury occ  (Street and Nur win, State)  cause(s) and ridate and place	24b. We come a company of their (Specurred annument as a, and due and (Month)	Vere eutopebbly  Vere eutopebbly  Vere eutopebble pompletion of death?	4 ☐ Unknown  by findings  fior to  of cause  2 ☑ No  Number,
	25. Was case referred to medical examiner?  1   Yes   2   No    27. Manner of Death  1   Natural	Hospital: 1 Inp 28a. Date of interpretation 28a. Place of building 28a. Place of building 28a. Place of building 28a. Place of building 28a. Place of building 28a. Place of building 28a. Place of building	Due to (c  Due to (c  Due to (c  Due to (c)  Injury Day Year)  Injury - At h., etc. (Specification of examinar stated.	EF/Outpatie 28b. Time of Injury ome, ferm, st	quence of):  quenc	OA Otto	26. Place her: 4 No No No No No No No No No No No No No	e of Deeti ursing Ho No	24a. Wesperful  1   24a. Wesperful  1   Check only  me 5   Res 28d. Describe  28f. Location (  City or To  end due to the ed at the time,	Yes 2 No en autopsy primed?  Yes 2 No No one) idence 6 Oo how injury occ  (Street and Nur win, State)  cause(s) and id date and place  29d. Date sign  July	24b. We of the control of the contro	Vers eutoposition of death?  Yes  ify)  ral Route  stated, to the cau  Dey, Yes  999	4 ☐ Unknown  by findings  ior to of cause  2 ☑ No  Number,  se(s)

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State of Maryland / Department of Health and Mental Hygiene 9 9 24 338

	Certificate of Death	Reg. F	り									
	Decedent's Nama (First, Middle, Last)	2. Data of Death	3. Time of Death									
Physician	Fliashoth M Coos	July 17	1999 6:25 am									
/Medical Examiner	As Essible Name III and institution aire street and august as		4c. County of Death									
Examiner												
10.10	Suburban Hospital Bet    5. Sociel Security Number   6. Sex   7. Age (In yrs. last birthday)   If Under 1 Year   If Under 24	hesda	Montgomery									
Funeral	1 M 277 F Months Days Hours	Min. (Month, Day, Yes	9. Birthplace (State or Foreign Country)									
Director	Usuel Residence of Decedent	March 16,	1923 Virginia									
P 1	10a. Stata 10b. County 10c. City, Town or Location		10d. Inside City Limits									
f short	Maryland Montgomery Bethe	-do	1 ☐ Yes 2 ☑ No									
vith the Marylt or 28e4 sho be notified at	Maryland Montgomery Bethes 100. Street and Number 101. Zip Code		Citizen of What Country?									
deeth with the Marylar rns 23e or 23e-f show croset be notified at												
her death the result in the result is the result in the re	9700 Fernwood Road 2081		United States									
	11. Marital Status  12. Was Decedent Evar in U,S. Armed Forces?  1 Never Married 2 Married  1 Yes, specify Cuban, Mexican, II Yes, specify Cuban, Mexican, II Yes, specify Cuban, Mexican, II Yes, specify Cuban, Mexican, II Yes, Section 1 Yes, Sect	n? (Specify Yas or No- Puerto Rican, etc.)	14. Race - American Indian, Bleck, White, etc.									
S # 24 P			Specify: TTIL 4 h =									
5-0020 72 hours after matural, or his fical Examins			white									
21215-0 ed within 72 ho sypiene. er than "naturi f, the Medical.	15. Decedent's Education 16a. Decedent's Usuel Occupation (Give kind of work done during most of life. DO NOT use retired)	of working 16b.	Kind of Business/Industry									
1121 within one. than	Elementary/Secondery (0-12) College (1-4or 5+)											
d 21	1 Homemaker		Own Home									
Barren and and and and and and and and and an		a Name (First, Middle, Meid	len Sumame)									
Via Ment	Tomas Fredma Oussen	Mary	Kent									
Aaryland 2 should be 1 2 should be 1 8 merhed of shumelic eve To Be	19e. Informent's Neme/Relationship (Type, Print)  19b. Meiling Addrass (Street end Number	or Rural Route Number, City	y or Town, Stete, Zip Code)									
re, Ma 1 and 2 Health ar Nem 27 is	Earle D. Goss, Jr. / Son 21900 Slidell Road	Boyds, Maryla	and 20834									
Or Heart of Heart	20a. Method of Disposition 20b. Place of Disposition (Name of	21 1000 20c.	Location - City or Town, Stete									
Page in the state of the state	1 Burial 2 Cremetion 3 Removal from Stete 4 Donation 5 Other (Specify)  Parklawn Memorial P		ckville, Maryland									
Baltimore, Maryland 21215-0020 semit. Pages 1 and 2 should be fliad within 72 hours at begantment of Health and Merical Hygiene. Important: If them 27 is marked other than "natural", or my journy or other traumetic event, the Medical Examples.  To Be Completed by F		air ko	ckviiie, Maryland									
B P P P P P P P P P P P P P P P P P P P	21. Signeture of Funeral Service Licensee  Robert A. Pumphrey Funeral Home/ Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase Inc 7557 Wisconsin Aven Bethesda, Maryland 20814-3501											
	23a. Part1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as a shock, or heart feiture.	ardiac or respiretory arrest,	Approximete toterval Between									
Physician	Shown, or result female. The second of each line.		Onset and Death									
/Medical	Immediate Cause (Final disease or condition  MCTASTATIC LYMPHO	an A	4 moull									
Examiner	Immediate Cause (Final disease or condition resulting In death)  ACTASTATICE Lymphos  Due to (or as a consequence of):  MOCENT Lymphosus		1									
\$	(As Day East ( Very the name )	New-Hodale	(cus) Jyn									
Box 68760, death certificate be executed of the conting physician and address as the burial-transit sticlan/Medical Examiner	Sequentially list conditions.  Due to (or es a consequence of):	7.00 01.04.0										
Exe	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury c.											
68760 efficate be a physician as the burial effical E	Cause (Disease or Injury c											
Aedi Aedi												
Box ath certification (contract)	d											
P.O. Box nat the death certain etached for use	Pert tl. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.	non Didantes	and the second death 2									
	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.		co use contribute to the cause of death?  2 No 3 Probably 4 Unknown									
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ecords, saw requires tr as been signe 2 should be d		24a. Wes an au	stopsy 24b. Were sutopsy tindings									
al Record The law require tate has been signage 2 should if	Hypothyruions	performed	? available prior to completion of cause									
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To the state of To	1 Yes 2 No Hospitel: 12 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nurs	sing Home 5 Residence										
الله مو مو الله الله الله الله الله الله الله الل	27. Manner of Death 1 Netural 5 □ Pending 28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury at Work?	28d. Describe how in	njury occurred									
Sio	2 Accident Investigation M 1 Yes 2 No	0										
Division of Division of Italian or Attending P and Division of Italian or Attention of Division of Div	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of tnjury - At home, ferm, street, fectory, office building, etc. (Specify)	28f. Location (Street City or Town, Str	and Number or Rural Route Number, ete)									
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Di Di Di Ne Hoepital or no 24 hours after ne Funeral Dir pletely lilled in	29a. Certifier (Check only  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death	place, end due to the cause	e(s) and manner as stated.									
2 6 2 7 0		occurred at the time, date e	and prace, and due to the cause(s)									
To the comment			Date signed (Month, Day, Year)									
15	Telene MD D0847	0 1	July 17, 1984									
	30. Name end address of person who completed cause of death (Item 23a) (Type. Print) /0 400 C.	ONNELTICUT	AUE									
	30. Name end address of person who completed cause of death (Item 23a) (Type, Print) 10 400 Con EUGENE P. LIBRE M-D REWINGS	TIM, MD.	20895									
State	31. Dete filed (Month, Dey, Year) 32. Registrar's Signature											
Registrar	IIII 9 0 1000 Ferres 4											



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death July **Physician** John 18:00 M. Grahek /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospita Suburban Bethesda Montgomery If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months 380-16-0182 1 M 2 F 80 Michigan Director Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Directo 288-7 Maryland | Montgomery Potomac 8 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 8 238 20854-1533 11200 River Road United States Funeral thems: 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: 14. Race - American Indien, Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Stetus Black, White, etc. the Medical Examiner filed within 72 hours after Hygiene. ther then "natural", or its 1X Never Merried 2 Married 1 Yes 20 No Specify: 21215-0020 Specify: à 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Construction Handyman Baltimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if fleen 27 is marked other any injury or other traumatic event pages. 17. Father's Neme (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Be Ann Ghena John Grahek 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 20854-1533 Verna G. Mize/Sister 11200 River Road, Potomac, Maryland 20b. Plece of Disposition (Name of cemetery, crematory or other place) July 20, 1999 20a. Method of Disposition 20c. Location - City or Town, Steta 1 ☐ Burial 2 DCremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave. Bethesda, Maryland 20814-3501 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heer feiture. List only one cause on each line. M00803 Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediete Cause (Finel Aspiration disease or condition resulting in death) Examiner Due to (or es a consequence of): Examiner Gastrointestinal physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown knee amputations Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical axaminer? 8 26. Place of Deeth (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA of this 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Attending 1 Netural 5 Pending 1 Yes 2 No death. investigation 2 Accident Director: 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 24 hours after die Funeral Direct 4 ☐ Homicide 6 edical to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only onel 29b. Signature and title of certifie 29c. License number 29d. Dete signed (Month, Day, Year) 1/ance D 43517 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) 12515 Feldon Street, Silver Spring, Maryland Lawless, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State

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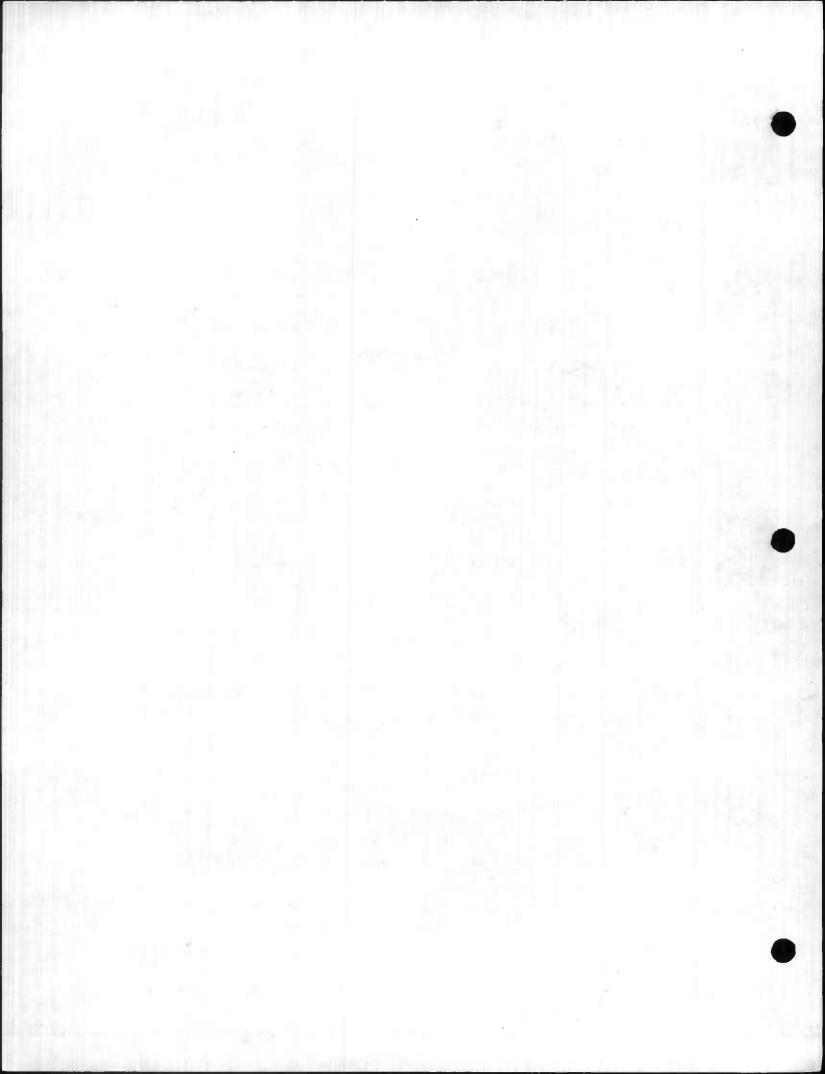
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State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Richard R. Hetrick 18, 1999 5:35 P.M. Ju1v /Medical 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 5513 CARVEL STREET CHURCHTON ANNE ARUNDEL If Under 1 Yeer If Under 24 Hrs. 5. Sociel Security Number 8. Date of Birth (Month, Day, Year) Sep. 11, 1933 Washington, DC Birthplace (State or Foreign
 Country) 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 F Months Hours 579-42-9913 Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28s-f show 1 ☐ Yes 2 ☑ No Director Maryland Anne Arundel Churchton 10a. Streef and Number 10f. Zip Code 10g. Citizen of What Country? 5513 Carvel Street 20733 USA 238 Funeral 14. Race - American Indien, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Never Merried 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give X b Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed WDivorced White Yeer or Detes: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Engineer Maintenance 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 88 Pages 1 and 2 should be nent of Health and Mental Mark Henry Hetrick Carrie Naomi Yorty 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Department of Health a Important: If them 27 is any injury or other tra Lynn H. Healey/ Daughter 7925 Fairfax Road Alexandria, Virginia 22308 20b. Placa of Disposition (Name of cemetery, crematory or other placa) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State 7-22-99 Grantville, PA 4 ☐ Donation 5 ☐ Other (Specify) Grantville Cemetery 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Cardiac Arryt /Medical Immedieta Cause (Final minutes disease or condition resulting in death) **Examiner** lige Physician/Medical Examiner JSC 144rs the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es a consequence of) P.O. Box 68760. Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3⊠Probably 4□Unknown 1 Yes 2 No Records, þ 24b. Wera autopsy findings available prior to completion of ceuse of death? Be Completed 24a. Wes an eutopsy 1 Yes 2000 certificate 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 No Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1 Natural s after death. 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 Homlcide within 24 hours a To the Funeral D completely filled i 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) end manner steted. 29e. Certifier edical To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end fitle of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) West Blarbaun CVayne 34

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

JUL 2 0 1999

NU 20 1999 James D. April

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Year 13, HOUSTON JULY 1999 13:20 4a. Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month Day, Year)
Nov. 18, 1920 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) N 2 □ F 78 Yrs Olyphant, PA. 10b. County 10c. City, Town or Location 10d. Inside City Limits Anne Arundel Lothian 1 ☐ Yas 2 ♥ No 10f. Zip Coda 10a. Citizen of Whet Country? 20711 USA 12. Was Decedant Evar in U,S. Armed Forcas? 14. Race - American Indian, Black, Whita, atc. Wes Dacedant of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) MYYas 2 No WWII If Yes, Give Yaar or Datas: 1 Navar Marriad 2 Married 1 ☐ Yes 2 No Specify: White Specify: 3 Widowed 4 Divorced 16a. Decedant's Usual Occupetion (Giva kind of work dona during most of working iffe, DO NOT usa retired) 15. Decedent's Education 16b. Kind of Businass/Industry (Specify only highast grada completed) Collega (1-4or 5+) Lithographer Newspaper 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surname) Alovsius S. Houston Helen McKenna 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) Jean E. Houston/Wife Same as item 10 20b. Place of Disposition (Nama of cemetary, cramatory or other place) Data 20c. Location - City or Town, State 1 Burial 2 Cramation 3 Ramoval from Stata Maryland Veteran's Cem. 7/16/99 | Cheltenham, MD. 5 Othar (Spacify) 21. Signature of Funeral Sarvice Licensee 22. Nama and Addrass of Facility George P. Kalas Funeral Home, P.A. do 2973 Solomons Island Rd., Edgewater, MD 21037 The the disease, or complications that grused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, or heart failure. List only one cause on the china. Approximata Intarval Between Onset end Daath Dua to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings available prior to complation of causa of daath? 24e. Wes en autopsy performed? 1 ☐ Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Inpatiant 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 28b. Time of 28d. Dascribe how Injury occurred 28c. tnjury at Work? 1 Yas 2 No

**Physiclan** /Medical Examiner buriel-transit

and physician s the buriel

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page 2

certificata

Hospital or Attending Physicien: 24 hours efter death. Funeral Director: After this certifice

To the Hospital within 24 hours or To the Funeral Completely filled

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Completed

Be

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Certification:

Medical

Division of Vital Records. P.O. Box 68760.

The law requires that the been signed by should be detac

**Physician** 

/Medical

Examiner

**Funeral** 

Director

the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentel Hygiane. Important: If item 27 is marked other than "naturel", or items 23e or 28e-1 show eny injury or other traumatic event, the Medical Examer must be confined any injury or other traumatic event, the Medical Examer must be confined as

Baltimore, Maryland 21215-0020

JOSEPH

5. Sociel Security Number

10a Stata

Director

Funeral

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11. Marital Status

10e. Streat and Numbar

218-18-1717

Usuel Rasidance of Dacedani

112 5th St.

Elamantary/Secondary (0-12) 12th

20a. Method of Disposition

4 Donation

Examiner Sequantially list conditions, if any, laading to immadiata ceusa. Entar Underlying Causa (Disaasa or Injury that initiated evants rasulting in death) Last Physician/Medical

Immediate Cause (Final disease or condition rasulting in death)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.

25. Was cesa raterred to medicel axaminar? 1 Yas 27. Mannar of Daath 1 Natural

5 Panding invastigation 2 Accidant 6 Could not ba 3 ☐ Sulcidé 4 Homicide

28a. Place of Injury - At home, farm, straat, factory, office building, atc. (Specify)

28f. Location (Streat and Number or Rural Route Number, City or Town, Stata)

29a. Cartifian 29b. Signature end Mile of

Certifying Physician: To tha best of my knowledge, deeth occurred at tha time, date end plece, and due to the ceuse(s) end menner as steted.

2 Medical Examiner: On tha basis of exeminetion and/or investigation, in my opinion, daath occurred at tha tima, data and place, and dua to the cause(s) end mannar stated.

29c. Licansa number

29d. Date signed (Morgin, Day, Year)

30. Name end edd Davi

d cause of deeth (Item 23a) (Type, Print) Gallatin, M.D.,

Prince Frederick, MD. 20678

State Registrar

31. Date filed (Month, 32. Registrar's Signatura 1 6 1999

me to perter

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** EDA B. HAMILTO N 100 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges' Hospital Center

Social Security Number 6. Sex 7. Age (In vrs. la Cheverly Prince Georges' If Under 1 Year if Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1□M 210 F 80 **Director** 214-30-2370 Usual Residence of Decedent April 18, 1919 Virginia the Marylend 10a. Stata 10b. County 10c. City, Town or Location - Nove 10d. Inside City Limits r 28a-f show 1 ☐ Yas 2 ☑ No Director Upper Marlboro Maryland | Prince Georges' 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? death with r than "natural", or items 23s or the Medical Examiner must be 3809 Largo Road Funeral 20772 United States 12. Was Decedent Evar in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status 14. Race - American Indian. Black, White, etc. filed within 72 hours eftar a Hygiena. Wher than "natural", or item 1 ☐ Yes 2½ No If Yes, Give Yaar or Dates: 1 Never Married 2 Married Raltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: p 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker .. Peges 1 and 2 should be filed w fment of Heelth and Mental Hygies tant: If Nem 27 Is marked other to fury or other traumatic event, to 8 Own Home other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be Lewis Cubbage Lucy F. Pence 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5801 Woodyard Road, Upper Marlboro, Maryland 20772 of Disposition (Name of Data 20c. Location - City or Town, State Judy F. Hamilton-Daughter 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Ramovai from Stata permit. Pege Department of Important: If any Injury or pnce. 4 ☐ Donation 5 ☐ Other (Specify) George Washington Cemetery 7-21-99 Brentwood, Maryland 21. Signature of Funeral Service Liber 22. Nama and Address of Facility Fort Lincoln Funeral Home Part 1. Enter the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest,

Approximate shock, or heard failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel CHRONIC RESPIRATORY FAILURE weeks disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner PULMONEARLY DISEASE CHRONIC OBSTRUCTIVE burial-transit certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue Due to (or as a consequenca of) physician s the burial Physician/Medical Dua to (or as a consequenca of). 88 980 Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. P.0. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Serile dementing with Psychotic Division of Vital Records. þ 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peen has page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Piece of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Rasidenca 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28e. Date of injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1-Neturai 5 Pending after death. Director: Aft 1 Yes 2 No 2 Accident Invastigation 3 Suicida 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, straet, factory, office building, etc. (Specify) 4 Homicide 5 24 hours Hospital edicai 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) and manner as steted. completaly (Check only one) 2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. To the I within 2 29b. Signature and title of cartifier, 29c. Licansa number 29d. Data signed (Month, Day, Year) ales 022780 Muy 39 Neme and address of person who completed cause of death (item 23a) (Type, Print)

Ctr br. Greenbelt Md 20770

Registrar

State

8

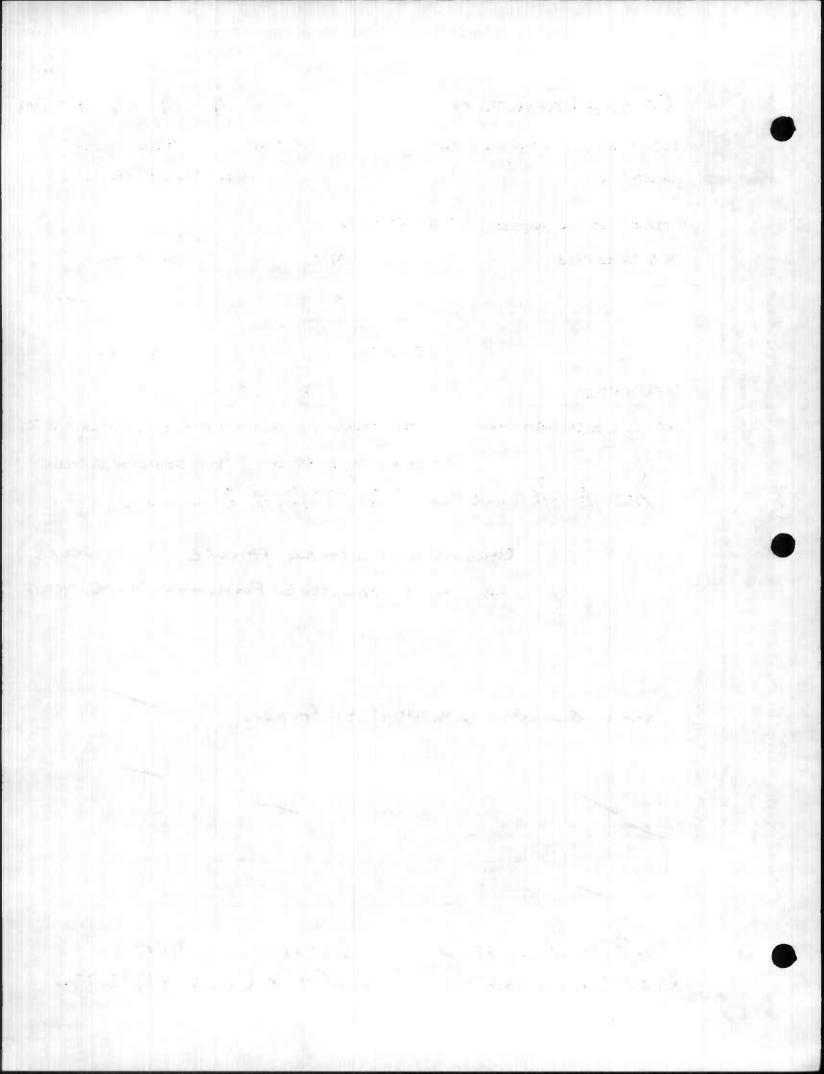
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31. Date filed (Month, Dey, Year)

chissler MD 7500 Greenway

32. Registrar's Signature

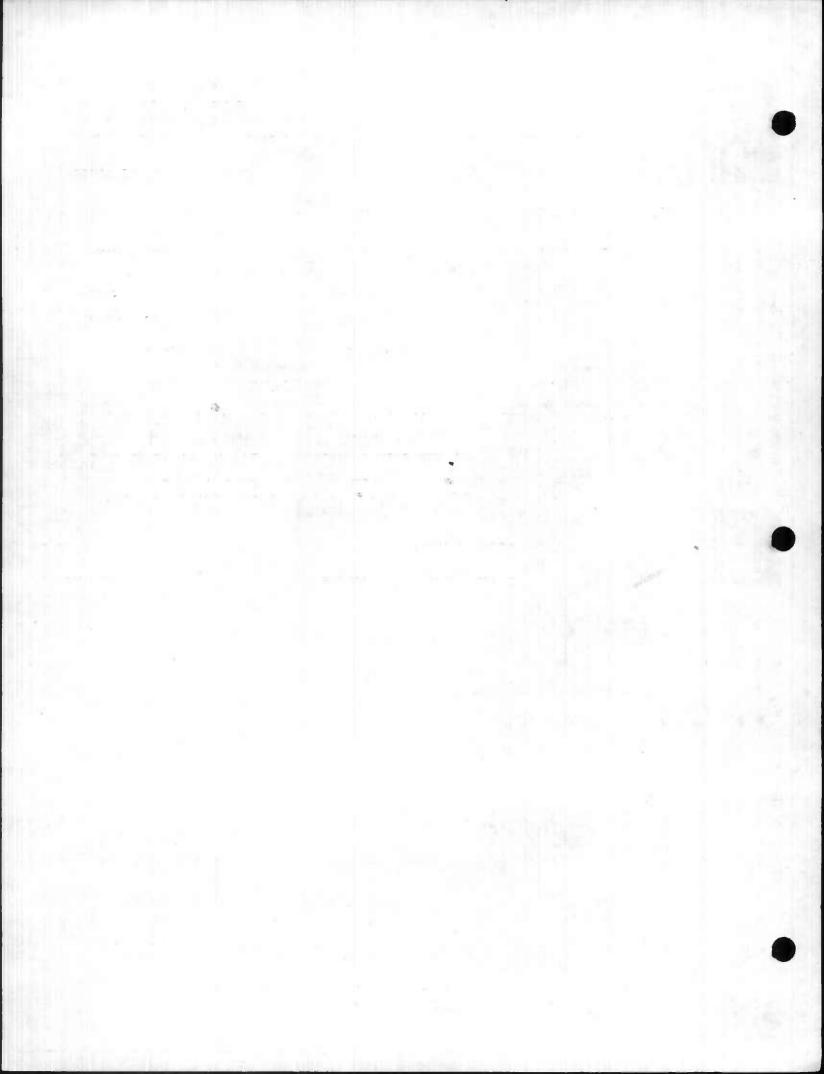
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### Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** WARD HARRIS 19 1999 9:25 JUL Y AM /Medical 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BROOKE GROVE NURSING HOME SANDY SPRING MONTGOMERY If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1 M 2 ☐ F 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Yrs. 225 05 6355 Director 87 SEPT.24,1911 VIRGINIA Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits mast be notified at MD. MONTGOMERY 1 Yes 2 No GAITHERSBURG Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 24211 LAYTONSVILLE ROAD 20882 UNITED STATES Funeral Herna Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. The Medical Examiner filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give 21215-0020 8 1 Yes 2 No Specify: Specify: WHITE p 3 ₩Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) 8 LANDSCAPER LANDSCAPING 7 is marked other traumatic avent, Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fit ment of Heelth and Mentel Hant: If item 27 is marked oth jury or other traumatic aven Be **GEORGE** HARRIS MINERVA HARGRAVES 2 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOANN McCORMICK, DAUGHTER 17821 BUEHLER ROAD, #106, OLNEY, MD. 20832 20b. Plece of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cometery, cremetory or other place) 1 Burial 2 Cremetion 3 Removel from Stete permit. Page Department of Important: If any injury or once. 4 ☐ Donetion 5 ☐ Other (Specify) LAYTONSVILLE CEMETERY 7/22/99 LAYTONSVILLE, MD. 21. Signeture of Funerel Service Licenses 22. Name and Address of Fecility
MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical RENAL FAILURE Immediete Cause (Final 3 MONTHS disease or condition resulting in death) Examiner Due to (or as a consequence of):
CEREBROVASCULAR ACCIDENT Examiner 30 YFARS The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue Due to (or es e consequence of): Box 68760. physiclan Physician/Medical the Due to (or es a consequence of): USB signed by the at d be detached for 23b. Did tobecco use contribute to the cause of death? Part II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Pert I. of Vital Records, P.O. 3 Probably 4 SUnknown 1 ☐ Yes 2 ☐ No ρ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed **page 2** certificate has 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director, 25. Was case referred to medical axaminer? Medical Certification: To Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient Other: 4/25(Nursing Home 5 - Residence 6 - Other (Specify) 1 Yes 2 No 3 DOA 2 ER/Outpatient After this 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. tnjury at Work? 5 Pending investigation Division To the Hospital or Attantons within 24 hours after death.

To the Funeral Director: After To the Funeral Directors of the fur 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature of partitle of certifier 29c. License number cerul JULY 20,1999 30. Nema and address of person who completed cause of deeth (Item 23a) (Type, Print) Piccard Dr. Rockville, MD 20850 396 Carolyn Baier 31. Dete filed (Month, Dey, Year) 32. Registrer's Signature State JUL 21 Menera Registrar



Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First Middle Last) 3. Time of Death 2. Date of Death Day **Physician** Elizabeth July 20, 1999 Harrison 1:20 PM /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1506 Highland Drive Silver Spring Montgomery Winder 24 Hrs. 8. Date of Birth Superior State of Foreign (Month, Day, Year) Superior Superior State of Foreign (Month, Day, Year) New York If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M ZXXF Days 94 Yes 076-09-1359 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits natural", or items 23s or 28e-f show dical Examiner must be notified at 1 Yes 2 No Director Maryland | Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 20910 1506 Highland Drive United States Funeral 14. Race - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Stetus filed within 72 hours after 1 ☐ Yes 2 🖺 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2KNo Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education
(Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Dining Room Worker Education 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) permi. Pages 1 and 2 should be fit.
Department of Health and Mental Hy
Important: If Item 27 is marked oth-any Injury or other traumatic even Be John M. Harrison Ellen Cronin 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clare Dell'Olio (Niece) 1506 Highland Drive, Silver Spring, MD 20910 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1) Burial 2 Cremetion 3 Removel from State St. Mary's Cemetery 7/23/99 Cortland, NY 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Metropolitan Funeral Service, Inc 21 Signature of Funeral Service Licenses 5517 Vine Street, Alexandria, VA 22310 234 Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, about, or than feilure. List only one cause on each line. Approximate Intervei Between Onset and Death **Physician** /Medical Immediate Cause (Finel 10 Days disease or condition resulting in death) Sepsis Examiner Due to (or as a consequence of): Examiner Years Dementia physician and the burial-transit the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of) 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown Vasomotor Instability ð 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 1 Yes 20XNo 1 Yes 20(No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home SWResidence 6 Other (Specify) To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Netural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Box 68760. 0.0 Division of Vitai Records, To the Hospital or Attending I within 24 hours after deeth.

To the Funeral Director: After completely filled in by the fune. edical

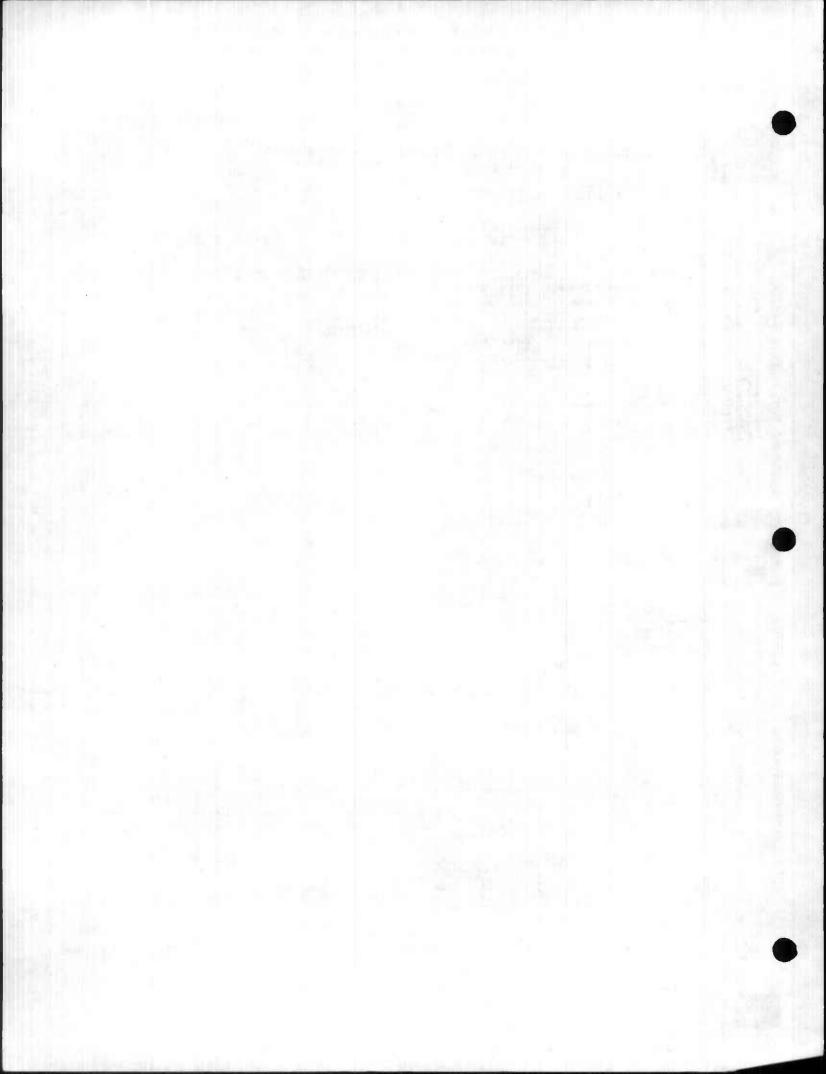
29a. Certifier 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) nerl nn 30. Neme and address of person wno completed cause of death (Item 23a) (Type, Print) 10301 Georgia Avenue, Silver Spring, MD 20902 Irnest S. Oser, M.D.

State Registrar

31. Date filed (Month, Day, Year) 32. Flegistrar's Signature 23 1999

porker



State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Month Physician July 15, 1999 0415 Ruth E. Hausafus /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Deys 1□ M 20 F Hours Months 577-09-4351 79 Director Dec. 21, 1919 Washington, DC Usual Residence of Decedent death with the Maryland 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits show r 28a-f show 1 XYas 2 □ No Directo Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be 504 Nelson Street 20850 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: p 3 Widowed 4 □ Divorced White Completed 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filled within neut of Health and Mental Hygiene. Intt if them 27 is marked other than ity or other treumstic event, its Me Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Secretary 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Sammuel Stockton Blackman Ella Dean 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a, Informant's Name/Reletionship (Type, Print) Robert C. Hausafus/Son 7108 Aquia Drive, Stafford, Virginia 22554 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) rimont riant: If Rockville Cemetery July 19, 1999 Rockville, Maryland 21. Signatore of Funeral Service Lice 22. Name end Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue 23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heert tailure. List only one cause on each line. 20850-2805 Interval Between Onset and Death **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical PNOLMONIA Examiner Due to (or es e consequence ot): Examiner EMPHYSEMA certificate be executed physician and s the burial-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Due to (or es a consequence of) Physician/Medical Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. P.O. 1 Yes 2 No 3 Probably 4 Unknown Dileuse. Artem Division of Vital Records. Àq 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Was en autopsy performed? Completed Deen certificate has 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 2 ER/Outpatient 3 DOA 1 //Inpatient this luneral 27. Manner of Deeth 28e. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After 5 Pending investigation 1 Netural 2 Accident ne Hospital or Attending n 24 hours after death. ne Funeral Director: Afte 1 TYes 2 No 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stele) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide to Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and manner as stated.

| Madical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and menner stated. edicai 29a. Certifier (Check only one) \$ within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartifier 0 0 20 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) 6220 Frederich Rd. Gas Theobony MD an ocuberga

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Dey, Yeer)

32. Registrer's Signature

Deneva

1999

20

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Months

State of Maryland / Department of Health and Mental Hygiene 99

24346 Certificate of Death

**Physician** /Medical Examiner

Harold Helfer 4a Facility Name (If not institution, give street and number)

Montgomery

July 18 to 1999 4b. City, Town, or Location of Death

2. Dete of Death

3. Time of Death 10:35AM

**Funeral** 

rithan "natural", or flems 23s or 28s-f show the Medical Examples must be notified at

Director

Funerai

py

Completed

Holy Cross Hospital 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) 10 M 20 F

Silver Spring 8. Date of Birth (Month, Day) 19,14

4c. County of Death Montgomery

Director

the Maryland

deeth

72 hours after

filed within 7 Hygiene.

permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygien. Important: if flem 27 la marked other that any injury or other traumatic avent, that pages.

Baltimore, Maryland 21215-0020

Usuai Residence of Decedent 10a State 10h Count

416-10-9722

1. Decedent's Neme (First, Middle, Last)

10c. City. Town or Location

Yrs.

10d. inside City Limits 1□ Yes 2□ No

9. Birthplace (State or Foreign Country) New York

Maryland 10e. Street and Number Silver Spring 10f. Zip Code

10g. Citizen of What Country?

White

8505 Springvale Rd. #45

13. Wes Decedent of Hispanic Origin? (Specify Yes or No II Yes, specify Cuban, Mexican, Puerto Rican, etc.)

United States 14. Race - American Indian,

1 ☐ Never Merried 2 ☐ Merried 3 NWidowed 4 Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes:

1 ☐ Yes 2 No Specify:

If Under 1 Yeer | If Under 24 Hrs.

Hours

Days

Bieck, White, etc. Specify:

15. Decedent's Education (Specify only highest grade completed)

College (1-4or 5+)

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

Elementary/Secondary (0-12)

85

Writer/Reporter

20910

Private

17. Father's Name (First, Middle, Last) Sam Helfer

19e. Informent's Neme/Retetionship (Type, Print)

18. Mother's Neme (First, Middle, Meiden Surneme) Rose Goldberg

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5 Franklin St. Middletown, MD. 21769

H.Mark Helfer/Son 20a. Method ol Disposition

1 Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Judean Memorial

20c. Location - City or Town, Stete 7/21

Olney, MD.

21. Signature of Francial Segree Light

22. Name and Address of Fecility

Takoma Funeral Home.

254 Carroll St.NW Washington, DC. 20012 death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximata Interval Between Onset and Deeth

**Physician** /Medical Examiner

attending physician and for use as the burlet-transit

signed by

Deen page 2

To the Hospital or Attending Phys within 24 hours after death.

To the Funerel Diractor: After this completely filled in by the funeral di

Box 68760. certificate be

Records, P.O.

Division of Vital

Examiner

by

Completed

Be

2

Certification:

edical

Immediate Cause (Finel disease or condition resulting in death)

Congestive Heart Failure Due to (or as a consequence of)

Due to (or as a consequence of)

Years

Arterosclerosis

Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical thet initiated events resulting in death) Last

Due to (or as a consequence of):

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23h. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

Coronary Heart Disease

24a. Was an autopsy performed?

24b. Were eutopsy tindings available prior to completion of cause of death?

1 Yes 25 No

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

Hospitei: 1 Dinpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year) 5 Pending investigation

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

26. Place of Deeth (Check only one)

29e. Certifier (Check only one)

1 Naturai

2 ☐ Accident

3 ☐ Suicide

4 T Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier for M. Houseur

WLD TE License number

29d. Date signed (Month, Dey, Year) 7-18-89

281. Location (Street and Number or Rural Route Number, City or Town, Stete)

410 30. Name and address of person who completed cause of death (item 23a) (Type, Print) GAAZIANI 6 HU 60

6 ☐ Could not be

8188

717 Perostion 6 M. 31 kg 20910

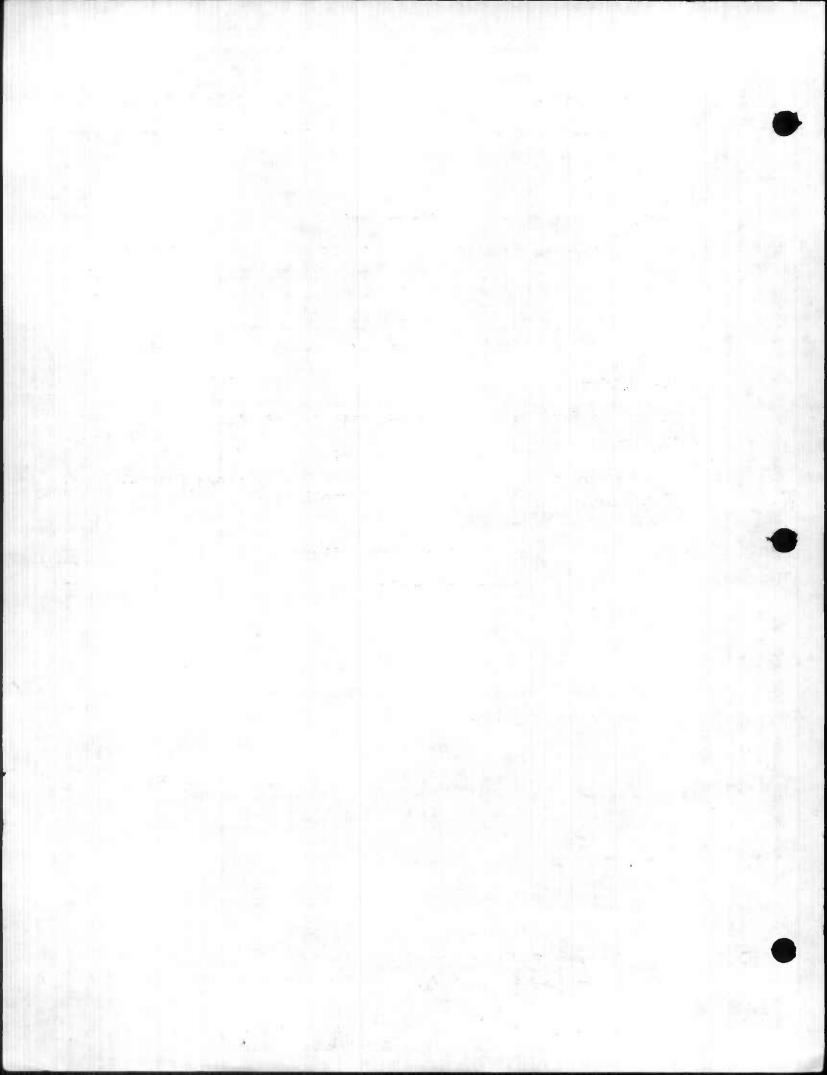
State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signeture

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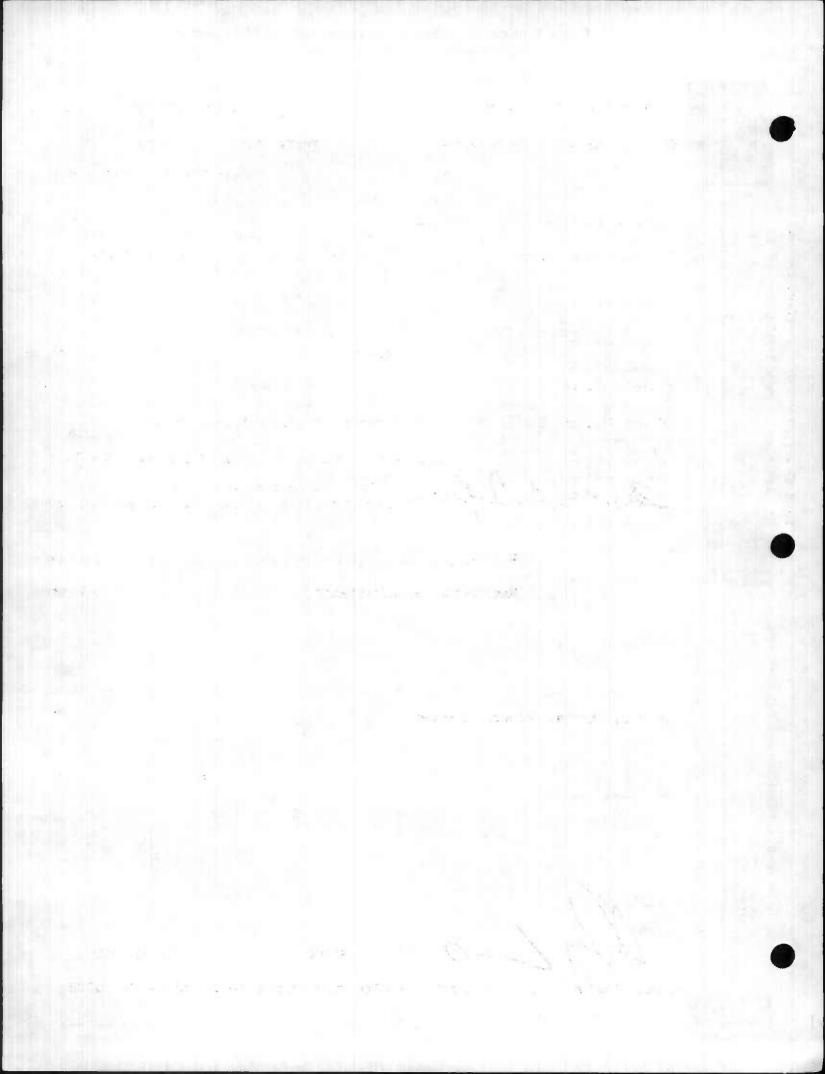
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						Cei	tificate o	f Death		Reg. No.	S-cop	7041
Discolate		1. Decedent's Neme	(First, Middle, La	ist)					2. Date of C	Peath Day	Year	3. Time of Death
Physician /Medical		Edward (	Griffith	Holland	1				July	17, 19		03:00AM
Examiner		la Facility Name (If	not institution, giv	e street and nun	nber)			4b. City, Town	n, or Location of Dec	th 4c. Count	y of Death	
		VA Maryla	nd Healt	th Care	System			Perry	Point	Ceci	1	
Funeral	5	5. Social Security Nu			7. Age (In yrs.		If Under 1 Ye		Hrs. 8. Date of B	irth (Pay, Year) 3, 1935	9. Birthp	place (State or Fore
Director		218-34-50	3 10	1 M 2□ F	64	Yrs.			June 1	3, 1935	Mary	Iand
		Usual Residenca of I	Decedent 10b. County		10c Cit	y, Town or Lo	cation					0d. inside City Lim
sho sh	.		•				odilon					1X Yes 2□1
or 28s-1 s	90	Maryland	Charles		wal	dorf	Tan 7: 0:4			40. 0	MP 0	
9 5		10e. Street and Num					10f. Zip Code	9		10g. Citizen of		•
ma 23a or 28a-1 show	E .	1307 Gre	enmont D		4 E	0 140 1	20601		. 0. /D 'A- V b	United	Stat ce - Americ	
natural, or item	Š	<ol> <li>Marital Status</li> <li>Never Marrie</li> </ol>	d 20 Marriad	Armed For	dent Ever in U	,5.	f Yes, specify C	uben, Mexicen,	n? (Specify Yes or I Puerto Rican, etc.)	Bla	ck, White,	
"aturat", or forms 23s or 28s-1 show edical Exercines must be notified at lefted by Furnerial Director	by Funeral	3 Widowed 4		If Yes, Give	6 190		I□Yes 2XIN	lo Specify:		Specia	y: Bla	.ck
and a	- g		15. Decedent's E			16a, Deced	lent's Usual Occ	cupation		16b. Kind of E	lusiness/in	dustry
Tel.	To Be Completed	(Specif	y only highest gr	ade completed)		(Give	kind of work do OO NOT use ret	ne during most o ired)	of working			,
than	E	Elementery/Secon	dary (0-12)	College (1	-40r 5+)	Pres	ident			Hollan	d Con	struction
d other event, t	0	17. Father's Name (F	irst, Middle, Last	)				18. Mother	s Neme (First, Midd	e, Maiden Sume	me)	
marked or marked	0	Edward He	olland					Mary	Brooks			
PEE		19a. Informant's Nar	ne/Reletionship (	Type, Print)		19b. Meilir	ng Address (Stre	et and Number	or Rural Route Num	ber, City or Town	, Stete, Zip	Code)
# CV F		Edward He	olland	III /sc	n	1307	Greenmo	nt Dr.,	Waldorf,	MD 206	01	
	2	20a. Method of Dispo			20b. F	Placa of Dispo	sition (Name of netory or other p	place)	Dete	20c. Location	- City or To	own, Stete
			Cremetion 3 C		Siale		on Nati		7/23/99	Suitlan	d, Ma	ryland
Deperment of important: If any injury or DDCs.		21. Signature of Fun		all a	10		. Name and Add			1		
any ir		1 1/15	Ma	14/1	du				Service,			TO A LILE.
	-	23a Part1 Enter the	disease or com	inlications that of	used the deat	h Do not ent	400 Geo	rgia Av	e. N.W.,	Washingt	on, I	Approximate
voiolon		23a. Part1. Enter the shock, or heart	failure. List only	one ceuse on e	on line.			,	,			Interval Between Onset and Death
ysician Iedical		Immediate Ceuse (F	inel									
aminer	1	disease or condition resulting in death)		a Pneu	monia						1	ınknown
ةِ السا	ě			_	•	r es e consec					1	1.
in and hal-transit Examiner	Ē	Carrielle list and		b. Resp		ras a consec	ficienc	CY			1	ınknown
in an in an	ĽŽ	Sequentially list condition of the condi	nediete vina		0001010	, 45 4 55 755	30.100 01/1					
physician and s the burial-transit	S S	that initiated events		c	Due to (o	r es e conseq	uence of):					
Med we		resulting in death) La	ist								i	
for use	2			d								
d by the ettendileteched for use	200	Part II. Other signific	ant conditions	contributing to de	ath but not res	ulting In the u	nderlying cause	given in Part I.	23b. Di	d tobacco use co	ontribute t	o the cause of dea
by th	Ž.								1[	Yes 2□No	3 □ Pro	bably 4 💢 Unkn
be de	2	Anemia,	Stroke,	Seizure	disor	der						
	1 T								24e. We	es en eutopsy formed?	21	ere autopsy finding
ed h	9								_		CC	empletion of cause death?
s been signed by the ettend 2 should be deteched for us, bieted by Physician/	piered L		<u> </u>						**	Tyes 2□No	11	□Yes 2 No
has ye 2	ompieted t								1.8	Tes 2 INO		
pege 2	Completed	25. Wes case referre	d to medical					26. Place of				
ate has pege 2	ne Compieted	25. Wes case referre examiner? 1 ∐ Yes 2 ZMN		Hospitel: 1 🗆 Ir	npatient 2	ER/Outpatier	t 3 DOA	Other	of Deeth (Check only	one)	her (Speci	(y)
his certificate has al director, page 2	To be Completed	examiner? 1 ☐ Yes 2 ☑ N 27. Manner of Death	lo	1 1		28b. Time of	I SLI DOA	Other: 🙌 Nurs	of Deeth (Check only	one)		(y)
his certificate has al director, pege 2 To Be Comp	To be Completed	examiner?		28a. Date o	npatient 2  f Injury h, Day Year)		28c. ir	Other: 🙌 Nurs	of Deeth (Check onto	vone) sidenca 6 □Ot		(y)
tor: After this certificate has the funeral director, page 2 cation: To Be Comp	To be Completed	examiner?  1 Yes 2 XA  27. Manner of Death  1 X Naturel  2 Accident  3 Suicide	5 ☐ Pending	28a. Date o (Monti	f Injury h, Day Year) of Injury - At ho	28b. Time of Injury	28c. ir	Other: 4\(\sigma\) Nurs njury et Vork? \(\sigma\) Yes 2\(\sigma\) N	of Deeth (Check only sing Home 5 Re 28d. Describ	sidenca 6 Ote how injury occu	rred	ly) al Route Number,
leath.  or: Affer this certificate has the funeral director, page 2 cation: To Be Comp	To be Completed	examiner?  1 Yes 2 X A  27. Manner of Death  1 X Naturel  2 Accident	5 Pending investigatio	28a. Date o (Monti	f Injury h, Day Year)	28b. Time of Injury	28c. ir V	Other: 4\(\sigma\) Nurs njury et Vork? \(\sigma\) Yes 2\(\sigma\) N	of Deeth (Check only sing Home 5 Re 28d. Describ	v one) sidenca 6 □Ot e how injury occu	rred	
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DHMH 16 Rev 6/95



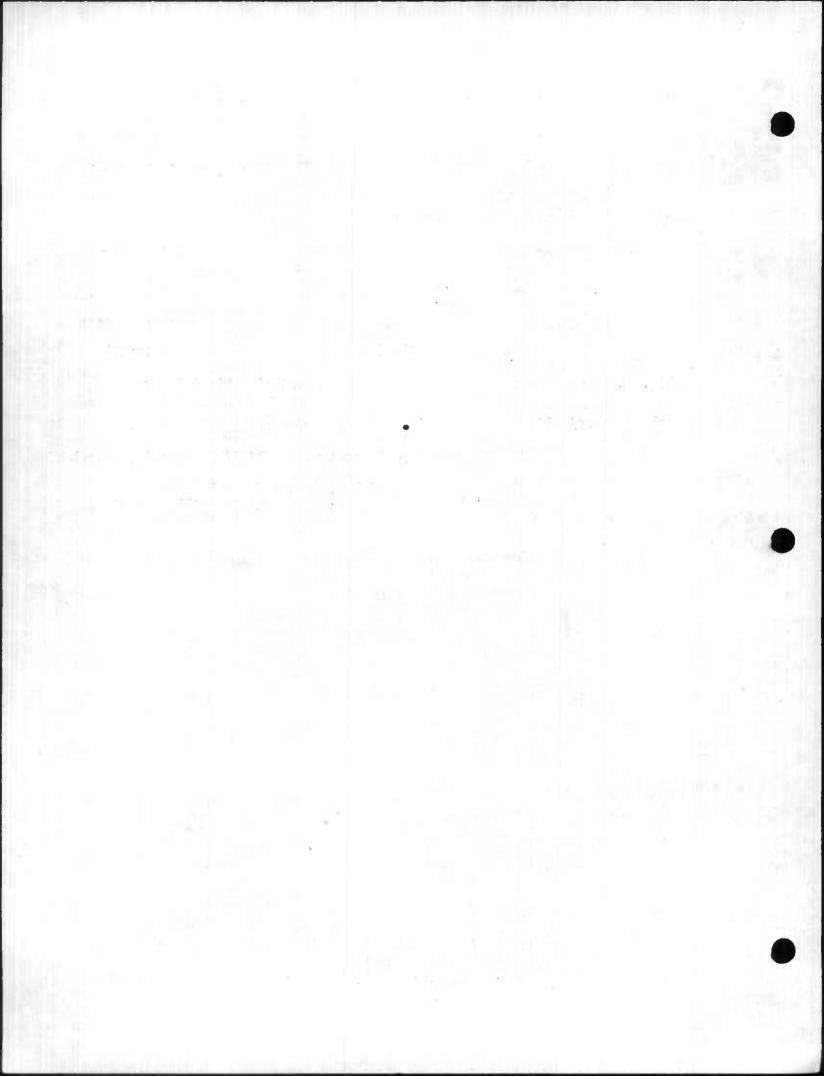
### Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legibie.

State of Maryland / Department of Health and Mental Hygiene Q 24348 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death JIII Y **Physician** KENNETH SR. W. HOWES 14 1999 6:15 PM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 18702 Curry Powder Lane Germantown Montgomery If Undar 24 Hra. 8. Data of Birth (Month, Day, Year) NOV. 22 1947 5. Social Sacurity Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (Stata or Foreign Country) **Funeral** Months Days Hours 1 M 2 □ F Yrs. 219-48-9596 51 Maryland Director Usual Rasidance of Decedant the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 to No Maryland Montgomery Director Germantown 28a-f 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? mast be 18702 Curry Powder Lane 20874 United States Funeral Status . 11 Marital Status 12. Was Decedant Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, White, atc. filed within 72 hours after 12 Yas 2 No 1972-1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: à White 3 Widowed 4 Divorced Yaar or Datas: 1973 Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Glazier Construction 12 18. Mother's Name (First, Middle, Maiden Sumama) 17. Father's Name (First, Middle, Last) 88 Pages 1 and 2 should be nent of Health and Mertal Elias Woodrow Howes Marjorie Virginia Oden 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) ä of Health i Item 27 to other tra Darlene Howes/ Wife 18702 Curry Powder Lane, Germantown, Md. 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematery, cramatory or other place) Data 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Ramoval from Steta = 8 Department o Important: If any injury or Mt. Carmel Cemetery 7/17/99 Sunshine, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 22. Name and Address of Facility
Muriel H. Barber Funeral Home 21. Signature of Funeral Service Licenses 0 au P. 0. Box 5038 Laytonsville, Maryland 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** tmmediate Cause (Finel disaasa or condition resulting in death) /Medical CENTRAL NERVOUS SUSTEM WEEK CARCINOMATOSIS Examiner Dua to (or as a consequence of): Examiner YEAR MULTIPLE MYELOMA The law requires that the death certificate be executed burial-transit Sequentially list conditions, if any, laading to immediate causa. Entar Undarlying Cause (Disease or injury that initiated evants resulting in daath) Last Due to (or as a consequence of) pur physician as the buriel Box 68760. Physician/Medical Dua to (or as a consequanca of): 98 OSD been signed by the a should be detached Part It. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 LUnknown of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 has 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate Physician: 25. Wes case raferred to medical axaminer? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Homa 5 ☑ Residence 6 ☐ Other (Specify) Certification: To 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Time of tnjury 28d. Describe how injury occurred 28c. Injury et Work? Affer Division or Attending 1 Natural 5 Panding n 24 hours after death.

Ne Funeral Director: After the further than 10 to 10 1 Tes 2 No invastigation 2 Accident 6 Could not be determined 3 ☐ Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Pleca of Injury - At homa, farm, street, fectory, office building, atc. (Specify) 4 Homicida Hospital 29e. Cartifier Medical 1🔁-Certifying Physician: To the best of my knowledge, daeth occurred et the tima, date and place, and due to the cause(s) and manner as stated. within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of axaminetion end/or investigetion, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and mannar stated. To the 29d. Data signed (Month, Day, Year) 29b. Signature and titla of certifier 29c. License number wo MD + D 45274. July 16, 1999 12 30. Nema and addrass of person who completed causa of deeth (Item 23a) (Type, Print) 10810 Connecticut Ave., Kensington, Maryland Cho Maung, M.D. 31. Deta filed (Month, Day, Year) 1999

State Registrar

32. Pegistrar's Signatura



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible

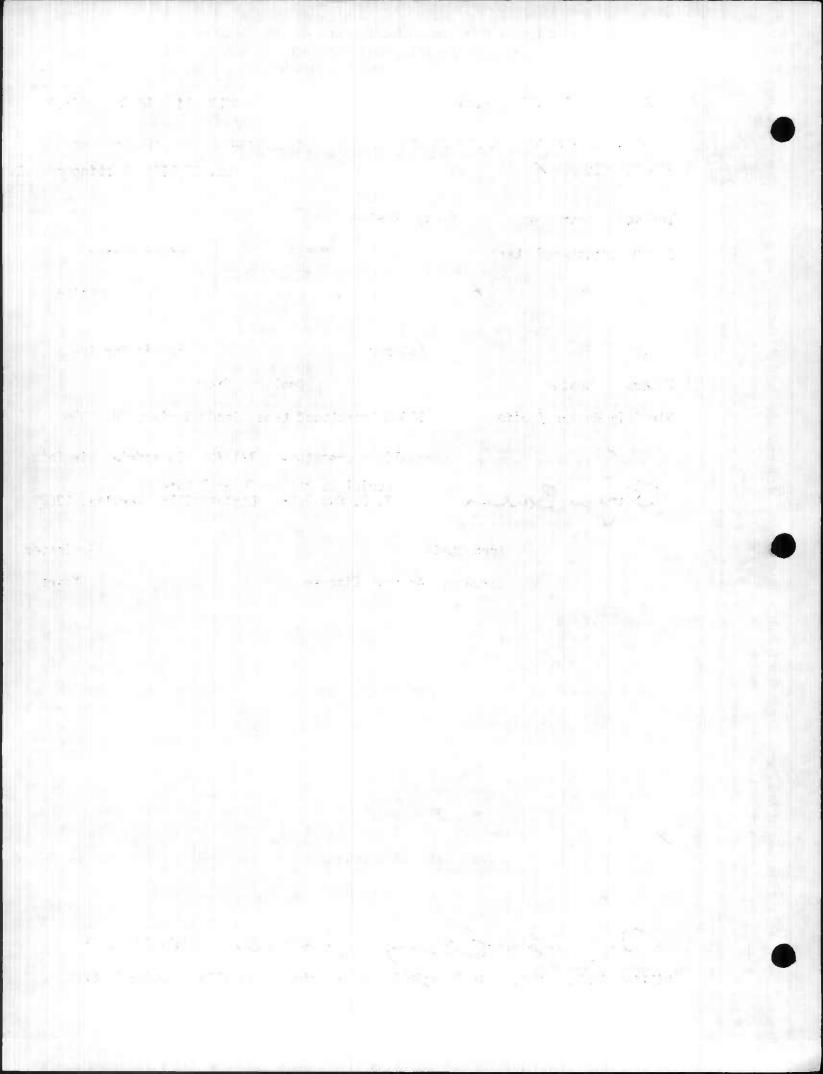
				State of Ma	arylan		epartment Certificate		lealth and N Death	Mental Hy	giene 9	9	243	349
	Physici /Medic		Decedent's Nama (First, Middle, Las GEORGE EDW.		ITER					2. Date of De		9 9 9 gar		e of Death
	Examir		4a Facility Name (If not institution, give	street and number)					4b. City, Town, or Lo	ocation of Deat	h 4c. Coun	y of Death	1	
			SHADY GROVE			SPI			ROCKVI	LLE	MO	NTGO	MERY	7
	Funeral Director		LEG 30 LOL3	X 7. Ag M 2□ F	6 (In yrs. I 58	ast birtho	Months   1	Year Days	if Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D) Feb.	18,1941	9. Birth	placa (Sta	on D.C
	ylend		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town o	r Location							a City Limits
	8 Me	Director	Maryland Montgor	nery	San	dy	Spring							Yes 2□No
	death with the Meryland ms 23a or 28a-f show		10e. Street and Number 18009 Branchwood	d Lane			10f. Zip C		0860		10g. Citizen of United			
	eath 23	era	11. Marital Status	12. Was Decedent	Ever in 115	9	13 Was Deceder			ecify Yes or N			ican India	1
020	n 72 hours after death with the Merylen "natural", or items 23a or 28a-f show edital Examine must be notified at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1  Yas 2 1  if Yes, Give Year or Dates:		3.	If Yes, specify		dispanto Ortgin? (Sp an, Maxicen, Puarto Specify:	Ricen, atc.)	Spec	ack, White		
2-0	"natur	leted	15. Decedent's Ed (Specify only highest grad	ucetion le completed)		(0	ecedent's Usual ( Give kind of work fe. DO NOT use	done	during most of work	ing	16b. Kind of	Business/I	ndustry	
7 7		Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)		orer	10010			Septio	Ser	vice	
and	should be filed within and Mentel Hygiene. marked other than amatic svent, the M	o Be	17. Father's Name (First, Middle, Last) Edward Hunter						18. Mother's Nem Beulah	e (First, Middle Fagar		me)		
Mary	0 0 0	-	19e. tnforment's Name/Relationship (7 Virginia Hunter)						ond Number or Run					50
ore,	permit. Peges 1 end Department of Health Important: If item 27 any injury or other tr ence.		20a. Method of Disposition 1 □ Burial 2 ★ Cremation 3 □	Removal from Stata	CE	em etery,	isposition (Name crematory or other	er pla		Date	20c. Location			
	Pen neur		4 ☐ Donation 5 ☐ Other (Specify	)	Met	ropo	litan Cr			/16/99	Alexan	dria,	Virg	ginia
Daiminor	permit. Peg Department Important: I any Injury o		21. Signature of Funeral Sarvice Licens	00.4			Muriel P. O. E	Н.	Barber F		Home	Marvl	and 2	20882
P	P. J. P. S. S.		23a. Part1. Enter the risease, or comp shock, or hear riture. List only	lications that ceused	the death	. Do no				or respiratory	arrest,		Approx	mata Between
	Physician /Medical Examiner		Immediate Cause (Finat disease or condition	Arrhy								1		inutes
ľ		ner	resulting in deeth)	Coror		Art	nsequence of): ery Dis	sea	se			1	Ye	ears
ć	be executed ician end budel-transi	Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying	D	Due to (or	as a cor	nsequence of):				Y			
00/00	death certificate be e ettending physicia of for use es the bu	Medical	Cause (Disease or Injury that initiated events resulting in death) Last	c	Due to (or	as a cor	sequence of):					-		7.49
200	th cer tendir or use	lan/N		d								1		
5	w requires that the death certificate be executed been signed by the ettending physician end should be detached for use es the buriel-transit	Physician/Med	Part II. Other significant conditions co	ntributing to death b	ut not resu	ilting in t	ne underlying ceu	use gi	ven in Part I.		tobacco use d			use of death?
SOLOS,	The law requires that the are hes been signed by the page 2 should be detache	Completed by									s an autopsy ormed?	8	Vere autopostaliable percompletion of deeth?	
	certificate hes rector, page 2	Comp								10	Yes 2 No		Yes	2 No
IIa	ertifica ector,	Be	25. Was cese referred to medical examiner?	11				Tay	26. Plece of Deel	th (Check only	one)			
5	Physic this o	70	1 105 21110	Hospital: 1 ☐ Inpatie	-	ER/Outp		•			idence 6 🗆 O	-	city)	
5	or Attending Physician: effer death. Director: After this certific in by the funeral director,	Certification:	27. Manner of Death  1  Natural 5  Pending  2  Accident investigation	28a. Date of tnju (Month, Da)		28b. Tin inju	Iry M	wo 1	rk?  Yas 2□No	280. Describe	how injury occ	nred		
	or Atte	ertific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubulging, etc.	ury - At ho :. (Specify	me, farm	, street, factory, o	office		28f. Location City or To	(Street and Num own, Stete)	ber or Ru	ral Route	Number,
	To the Hospital or Attending Physician: The lav within 24 hours effect death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical C	29a. Certifier (Check only one)  Certifying Phy 2 Medical Exam	sician: To the best of iner: On the besis of and manner sta	examinat	viedge, o ion end/o	leath occurred at or Investigation, in	the ti	me, date and place, opinion, death occur	and due to the red at the time	cause(s) and r date end place	nanner as , and due	steted. to the ceu	se(s)
	To the Comp	W	29b. Signature and title of certifier	oot	2		29c. 1	Licen:	se number	/	July 1			ar)
Ę			30. Name and address of person who of William Dooley,	ompleted cause of d	eath (Item	23a) (Ta	pe, Print)	r [	Orive, Roc	kville	. Marvl	and	2085	0

State Registrar 31. Date filed (Month, Dey, Year)

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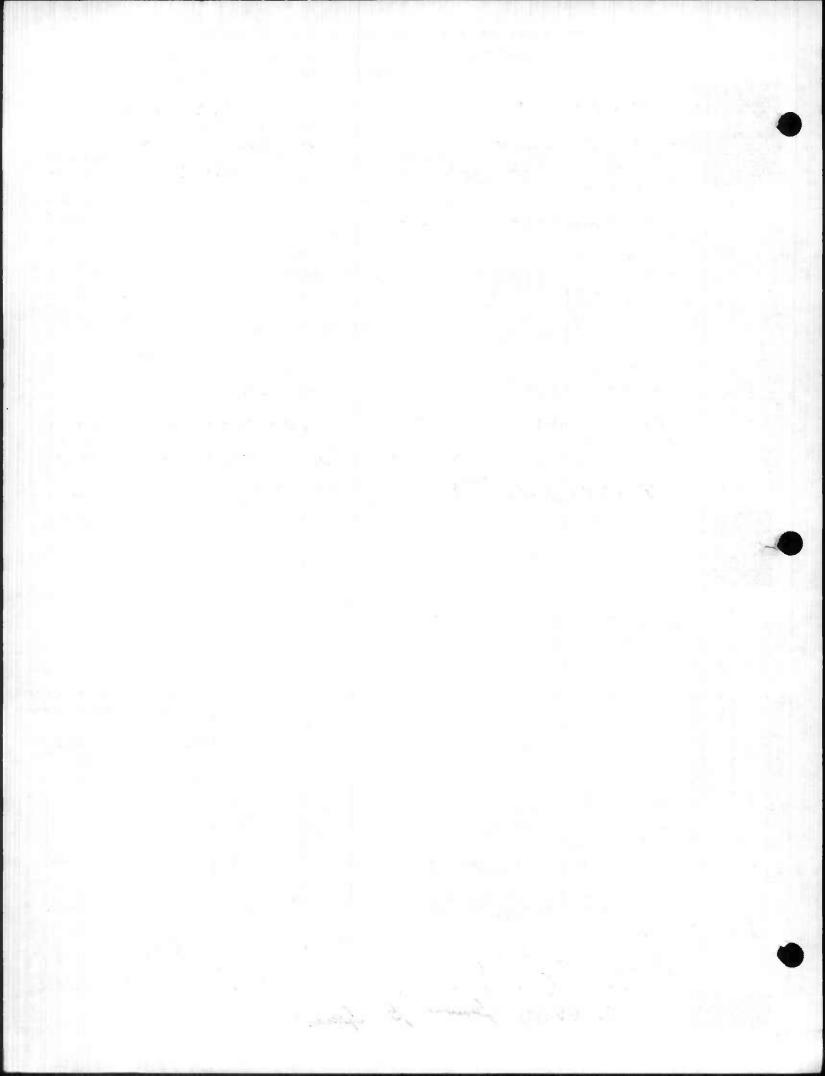
32. Registrar's Signature

Sports



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O

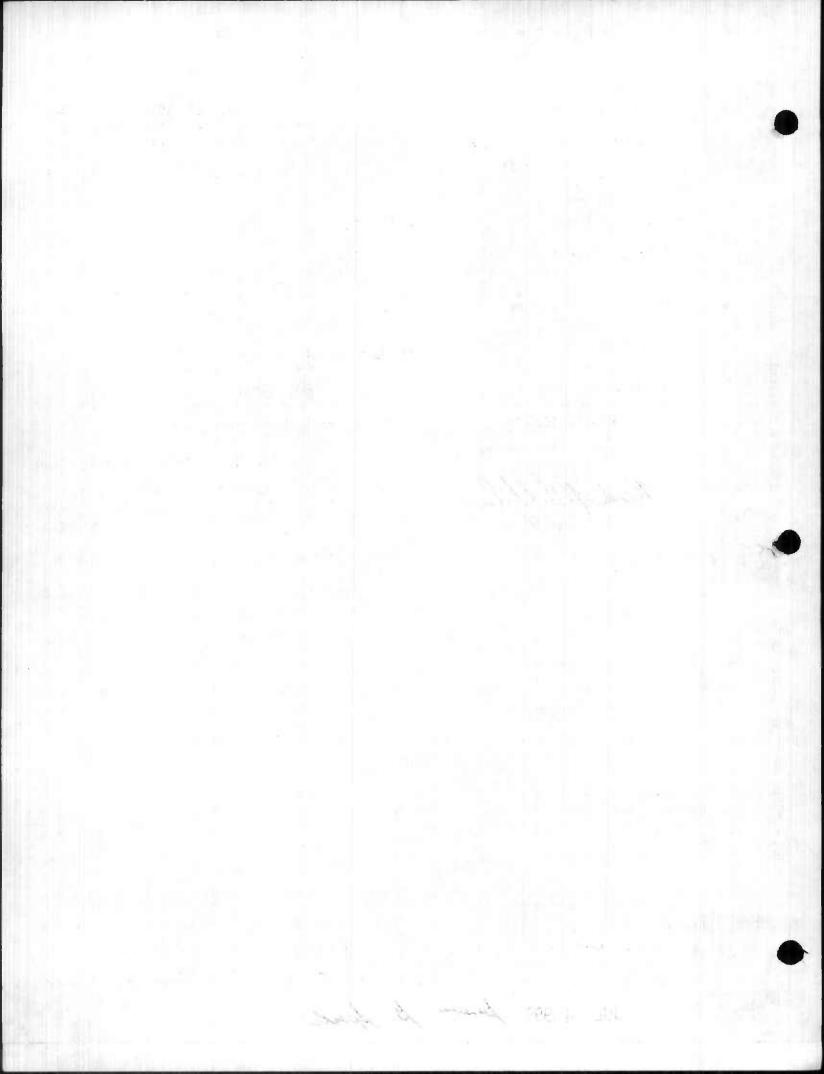
			Certificate of Death	u Mentai n	Reg. No.	24350
	Dhysisi	an	Decedant's Name (First, Middle, Last)	2. Date of D Month	Peeth Dey Ye	3. Time of Death
V. 1	Physici /Medio		Charles Clifton Holden	July	8, 1999	5:55 a.m.
	Examir	ner		or Location of Dea	th 4c. County of I	Death
			Magnolia Hall Nursing Center Chester  5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Yeer If Under 24		Kent	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. lest birthday) 1 Under 1 Year 1 Under 24 Nonths Days Hours North 1 Days 1 Under 1 Year 1 Under 24 North North Days North No	Hrs. 8. Data of B Month, L July 17	, 1907 Ch	Birthplace (State or Foreign Country) urch Hill, MD
	show		10a. State 10b. County 10c. City, Town or Location			10d. fnside City Limits
	Sa-f	Director	Maryland Queen Anne's Chestertown			1 Yes 2 No
	the de	Dire	10e. Street and Number 10f. Zip Coda		10g. Citizen of Wha	t Country?
	a 23a	ral	805 Bowers Road 21620		USA	
050	d 2 should be filed within 72 hours aftar death with the Meryland and Menfall Hygiens.  The marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at traumatic.	by Funeral	11. Maritel Stetus  1 Nevar Married 2 Named Forcas?  1 Nevar Married 2 Named Forcas?  1 Nevar Married 2 Named Forcas?  1 Nevar Married 2 Named Forcas?  1 Nevar Married 2 Named Forcas?  1 Nevar Married 2 Named Forcas?  1 Nevar Married 2 Named Forcas?  1 Nevar Married 2 Named Forcas?  1 Nevar Married Stetus  1 Nevar Ma	7 (Specify Yes or N uerto Rican, etc.)	14. Rece - / Bieck, V Specify;	American Indien, Vhite, etc. White
Maryland 21215-0020	uln 72 ho	Be Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usuel Occupetion (Give kind of work done during most of life. DO NOT use retired)	working	16b. Kind of Busin	ess/Industry
212	d with jiena. r thar	шо	Elementery/Secondery (0-12) 7 Collega (1-4or 5+) Farmer		Agricul	ture
מ	offie offie vent,	3e C		Neme (First, Middle	e, Meiden Sumema)	
ylaı	Menta Menta Parked	To	Thomas Wesley Holden Lydia V	Walraven		
Jar	2 sho		19a. Informant's Neme/Reletionship (Type, Print)  19b. Meiling Address (Street end Number of			
	and lasth		Louise E. Holden/Wife 805 Bowers Road, Che	T		
סכ	Pages nant of Hunt: If Ite		1 Burial 2 Cramation 3 Removel from State cematery, cremetory or other piece)	Date 7 /1 0 /00	20c. Location - City	
	it. Pa intmar reant. njury		4 Donation 5 Other (Specify) Church Hill Cemetery  21 Signature of Funesal Service Ligague 22. Name and Address of Facility	7/10/99	Church Hi	11, Maryland
Ba	permit. Pages 1 and 2 s Department of Heelth ar Important: If Item 27 le eny injury or other trau		Follows Holfonbo	ein & New Chesterto	mam Funera	al Home, P.A.
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car shock, or heart feilure. List only one cause on each line.	dlac or respiratory	arrest,	Approximete Intervai Between
~	Physician /Medical Examiner		Immediate Cause (Final diseases or condition resulting in death)  e. Arteriosclerite hear 7	1 1/	11-2	Vears
В		10	Due to (or es e consequence of):			
	uted Insit	Examiner	b			
ń	exect in and rial-tra	Еха	Sequentielly list conditions, if any, leading to Immediate cause. Entar Underlying Cause (Diseasa or injury c.			
68760,	ificata be executed physician and as tha bunal-transit	edical	thet initiated events	· · · · · · · · · · · · · · · · · · ·		
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Box	nth ce trendi	an	d			1
o o	the a	Physician/M	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Dic	d tobacco usa contril	outs to the cause of death?
S, T.	requires that the death certif een signed by the attending hould be datached for use a	by Ph	Chronic brondits	- 1	Yes 20 No 3[	Probably 4 Unknown
Hecords,	requir been s should	Completed		24a. Wa	s an autopsy 2 tormed?	4b. Were autopsy findings available prior to completion of cause of death?
= '	The law cate has b	Comp		1□	Yes 2 No	1 Yes 2 No
Vital	Physician: The this certificate in director, page	Be	examiner? Char.	Daeth (Check only	one)	
ō	Phys ral di	- T	1 Yes 2 No   1 Inpatient 2 ER/Outpetlent 3 DOA   Other: 4 Nursin   27 Meg/ner of Deeth   28a. Date of Injury   28b. Time of   28c. Injury et		sidence 6 Other (a	Specify)
-	0 8 8	tion	1 Netural 5 □ Pending (Month, Dey Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No	200. Describe	s now injury occurred	
_	노윤 등 c	Certification:	3   Sulcide 6   Could not be determined 28e. Piece of Injury - At home, term, street, tactory, office building, etc. (Specify)		(Street and Number o	r Rural Route Number,
	To the Hospital of within 24 hours at To the Funeral D completely filled it	edlcai C	29e. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end pl 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth o	ece, and due to the eccurred at tha tima	e cause(s) and manne s, deta and piece, and	or as stated. due to the cause(s)
	To the	Me	29b. Signeture and title of certifier 29c. License number		29d. Dete signed M	Ionth, Day, Year)
			16012 ws - ms P1648	3	7/8/9	9
		8	30. Name and address of person who completed cause of peath (item 23a) (Type, Print)	+	t	0 -11-
			wayne D ( Senjamin, mo, Che	341 lo	W, Ch	LA 21620
	Sta Registr	_	31. Diffe filed (Minth, Day, Year) 32. Realityst's Signeture		,	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 2435

						Certificate o	f Death		Reg. No.	F	,001
	10.55	. 11	1. Dacedant's Name (First, Middla, Las	st)				2. Date of D		14	3. Time of Death
	Physic /Medi		Mary Jane Hanifee					July :	Day 12, 1999	Yaar	1348
	Exami		4a. Facility Name (If not institution, give	street end number)			4b. City, Town,	or Location of Dea			1270
			Kent & Queen Anne	's Hospita	1		Chester	ctour	Kent		
Т	Funeral	П	5. Social Sacurity Number 6. Sa		a (In yrs. lest birt	hday) If Under 1 Ya	ar If Under 24 H		irth .	9. Birthp	piaca (Stete or Foreign
	Director		218-20-3440 <sup>1</sup> Usual Residence of Decedent	□M 2ĂF	72	frs. Months Day	rs Hours M	n. 8. Date of B (Month, D August	5, 1926 (	Coun	on, Maryland
	ylen		10a. State 10b. County		10c. City, Town	or Location				1	Od. tnside City Limits
	Mar	tor	Maryland Kent		Che	stertown					1 Yes 2 □ No
	h the	Te l	10e. Street and Number			10f. Zip Code	)		10g. Citizen of	What Coun	itry?
	13a c	Funeral Director	509 Cannon Street			216	20		USA		
	deat ms	Der	11. Maritat Status	12. Was Decedent	Ever in U,S.	13. Was Decedent of	f Hispanic Origin?	(Specify Yes or N	o- 14. Rad	e - Americ	
020	ges 1 and 2 should be filed within 72 hours after death with the Marylend to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumetic avant, the Medical Evantice must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	Armed Forces?  1 ☐ Yes 2 ☑ f  tf Yes, Give  Year or Datas:	No	1 ☐ Yes 2XX	uban, Mexican, Pud io <i>Specify:</i>	erto Hican, atc.)		ck, White, y: Whi	
21215-0020	n natu	Completed	15. Decedent's Ed (Specify only highest grad	de completed)		Decedent's Usuai Occ (Give kind of work dor life. DO NOT use ret	ne during most of w	rorking	16b. Kind of B	usiness/Ind	dustry
212	iene.	E	Eiementary/Secondary (0-12)	College (1-4or 5		les Clerk/	Asst Mar	nager	Sales		
D	Hygi Hygi other ant, II	BeC	17. Father's Name (First, Middle, Last)			LED GICERY		ame (First, Middle		ne)	
a	Mental Mental surked or	ToB	James Patrick Hani	fee			Lydia N	Jorman			
Maryland	2 should and Men is marke	-	19a. Informant's Name/Relationship (7		19b.	Mailing Address (Stre			ber. City or Town.	Stete Zip	(Code)
Ž	od 2 27 is 27 is		Allan T. Hanifee/H	Brother		l Pine Str					
ō,	tam tam othe		20a. Method of Disposition	2001102	20b. Place of	Disposition (Neme of		Date	20c. Location		own, State
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Itam 27 is any injury or other tra once.		1 ⊠ Buriat 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	)		ke Cremation	Center, II	¢ 7/17/99	Chester,	Maryla	and
Ra	Depar Impor any ir		21. Signatura of Funarat Service Licans	11111.	5	Fellows, He	I fonboin &	Newnam Fu	neral Home	e, P.A.	
	_		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	licens that caused	the death. Do n	ot enter the mode of d	ying, such as card	iac or respiratory	ryland 210 arrest,	20	Approximate Intervai Between
	/Medical Examiner	Examiner	Immediate Cause (Final disaasa or condition resulting in death)  Sequentially list conditions,		Due to (or as a confidence of the confidence of	onsequence of):	terest an oma				
Ď	an ar		if any, leading to immadiate cause. Enter Undarlying Cause (Disease or Injury							DC.	
68/60,	nte be	edical	Cause (Disease or Injury that Initiated events resulting in death) Last	C	Due to (or as a co	onsequence of):					
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o	law requires that the death co as been signed by the attend s 2 should be detached for us	Physician/									
5.	that the death led by the atter detached for a	ysi	Part II. Other significant conditions co	ntributing to death bu	ut not resulting in	the underlying cause	given in Part I.	23b. Dld	tobacco use co	ntribute to	the cause of death?
	that t		Alcohal A.	Bure.				1 🗆	Yes 2 No	3 Prot	bably 4 PUnknown
Hecords,	signed d be del	d by						040 14/0		24h 14/	ere autopsy findings
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ě	has I	Completed								of (	death?
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VITAI	Physician: The rhis certificate iral director, peg	Be	25. Was case referred to medicat examiner?	Unanitai:				eath (Check only	one)		
	his his	P	10 165 20 100	Hospitai: 1 🗷 Inpatie		patient 3L DOA		Homa 5□ Res			r)
DIVISION OF	Attanding P or death. ector: Affer I by the funera	atlon:	27. Manner of Death  1 Naturat 5 Pending  2 Accident investigation	1000		jury W	juryat /ork? □Yes 2□No	28d. Describe	how injury occur	red	
	7 1 2 2	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Piaca of injubuliding, etc	ury - At home, far c. (Specify)	m, street, factory, offic	8	28f. Location City or To	(Street end Numb wn, Stete)	er or Rura	l Route Number,
	To the Hospital of within 24 hours er To the Funeral D completely filled it	edical C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medicat Example	rsician: To the best of iner: On the basis of and manner sta	examination and	death occurred at the /or investigation, In my	time, date and pla opinion, death oc	ce, and due to the curred at the time,	cause(s) and ma date and place,	anner as st and due to	ated. the cause(s)
	roth withle roth	Me	29b. Signatura and title of certifier			29c. Lice	nse number		29d. Data signe	d (Month, i	Dey, Year)
		8	· Quela	•		129	3889		7/13/	99	
			30. Name and address of person who co	sme on	eath (ttem 23a) (1	Type, Print) of Wishing b. Spa	In Ave,	Cheste	a Form	Wed	21420
	Sta Registr		31. Date fited (Month, Dey, Yeer)  JUL 1 4 19		ar's Signature	G. In	w.,			1	
			T I K	/ /		- Jujura	as				



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Physician		. Decedent's Name (First, Middle,	200					2. Date of D Month	eath Day	Year	3. Time of Death
/Medical		ROBERT RAYMOND	HARE		1/			07	29	99	8:39 AM
Examiner	4	a Facility Name (If not institution,		)			4b. City, Town, or	Location of Dea	th 4c. Co	ounty of Dea	ath
	-	MEMORIAL HOSPI		ma /Im . um le		au) If Under 1 Yea	CUMBERLA r Munder 24 Hrs			LEGANY	
Funeral Director		Social Security Number  216-18-1011  July Residence of Decedent	1 XM 2 F	ge (In yrs. le 74	Yrs.	Months Days			ay, Year)	C	rthplaca (State or Fore country) IBERLAND, M
4 show fied at		Oa. Stete 10b. County  MD ALLEGA	NV		Town or			11/			10d. Inside City Lim 1 ☑ Yes 2 ☐ I
a or 28a-f st be notified Director	1	0e. Street and Number	14.1	COM	DEKLA	10f. Zip Code	-		10g. Citize	n of What C	ountry?
23a o unit ba		224 ARCH STREE	Т			21502			US		
E9 8	1	1. Marital Status	12. Was Decedent Armed Forces?	Ever in U,S	S. 13	3. Was Decedent of If Yes, specify Cu		Specify Yes or N			encan Indian,
Exam by	5	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced				1 ☐ Yes 2 ☐ No		to ruceri, etc.)		Black, Whi	
disal		15. Decedent's (Specify only highest			(Gi	cedent's Usual Occi	e during most of wo	nking	16b. Kind	of Business	/Industry
yolene, neturn A, the Medical, Completed		Elementary/Secondary (0-12)	College (1-4or	5+)	life	E POLICE	OFFICER				PARTMENT
Mental H infe even To Be	1	7. Father's Name (First, Middle, La JOHN WILSON HA					18. Mother's Na EMMA JA	me (First, Middle ANE BARC		ımame)	
in man	1	19a. Informant's Name/Relationship	(Type, Print)		19b. Me	ailing Address (Street	et and Number or R	ural Route Num	ber, City or T	own, State,	Zip Code)
m 27	-	WVU HGR		last at		BOX 912	28, MORGAN			506	
ant: If he ary or of	2	0e. Method of Disposition  1 ☐ Burlal 2 ☑ Crametion 3  4 ☐ Donation 5 ☐ Other (Spe		Ce	emetery, c	sposition (Name of trematory or other pl CREMATORY	lace)	7/30/9			r Town, State
Departr Imports any inju	2	21. Signature of Funerel Service Lic	ensee MA				,				
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nysician Medical xaminer	li c	23a. Part 1. Enter the disease, or conshock, or heert failure. List or mmediete Cause (Finel disease or condition esulting in death)		ENT	. Do not e	WVU HGR	9128, MOI ying, such és cardia	c or respiratory	N, WV arrest,	26506	Approximate interval Between
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Registrar

State

, M.D 205 JOHNSON HTS MED BLOG, CUMBERLAND, MD 21502.

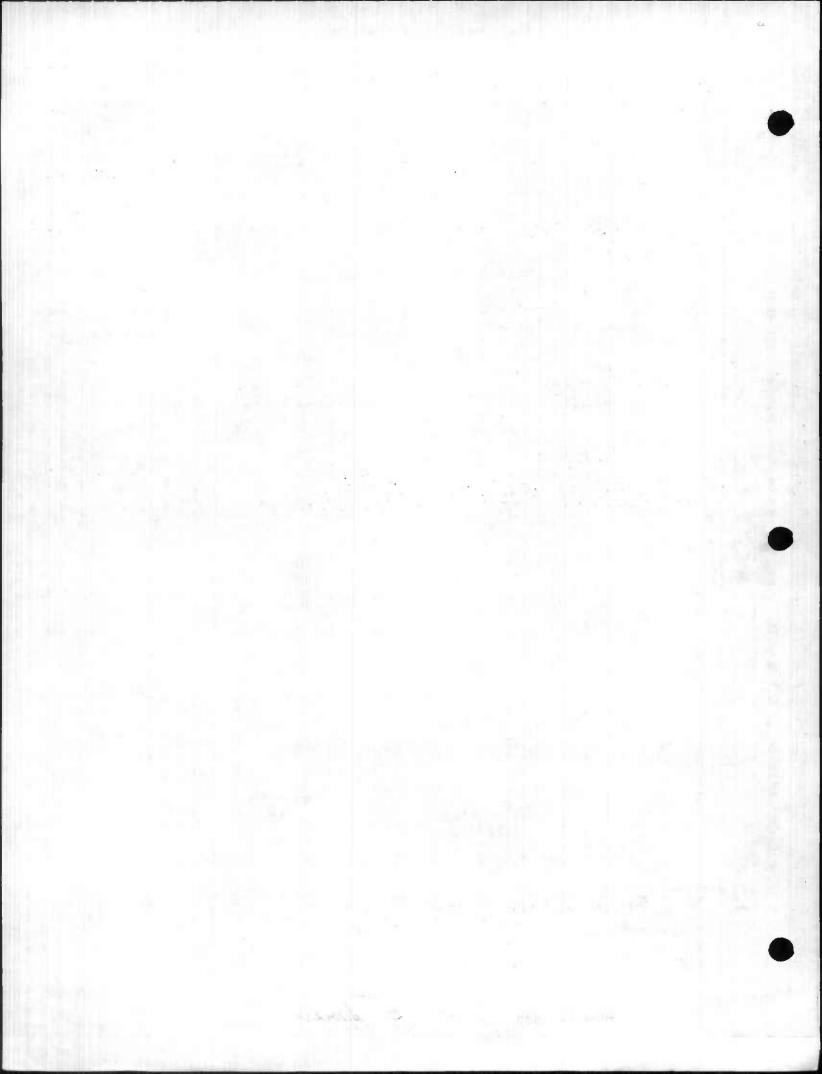
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature -

DINESH SHAM, M.D

31. Date filed (Month, Day, Year)

AUG 0 3 1999



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Dete of Deeth 3. Time of Death **Physician** Dey Francis William Hill 23 1999 July 11:45PM /Medical 4a. Fecility Neme (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shore Nursing&Rehabilitation Center Denton Caroline | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplacs (State or Foraign Months | Days | Hours | Min. | May 12 1911 | Connecticut 7. Age (In yrs. last birthday) 9. Birthplace (Stata or Foraign **Funeral** 1 □ M 2 □ F 077-16-0281 88 Yrs. Director Usual Residence of Decedent r 28a-f show 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits Caroline Denton Yos 2□ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? maniben 1030 Heritage Court 21629 USA Funeral Herra 12. Was Deceden! Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Yeer or Dates: 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bieck, White, etc. traumatic event, the Wedical Examiner 72 hours efter 1 Never Married 2 Married Specify: WHITE ò 1 ☐ Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced "naturel", Completed 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decedent's Education (Specify only highest greda complated) 16b. Kind of Business/Industry al Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Chemical Company Purchasing agent 12 4 Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic event. 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middla, Maidan Sumema) Arthur Francis Hill Susie Eileen Wheeler 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Route Number, City or Town, Stata, Zip Coda) 1030 North Heritage Court, Denton, Md. 21629 Edith Smith Hill/wife Baltimore. 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Capital Crematory 7/25/99 Dover, Delaware 22 Name and Address of Facility
100 PE ALLERAL HOME, P.A.
125. 2 4 St. DENTING MC 2/629 21. Signature of Funeral Servica Licenses 11/00/2 ort1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart feilure. List only one cause on each line. Approximete Intervei Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Z Wecks Carebrovoscular disease Examiner Due to (or as e consequence of): Fibrilation Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest and Due to (or as a consequence of): be execu Parkinsons disease Physician/Medical the Due to (or as e consequenca of): use es Box P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, þ Completed 24a. Wes en eutopsy performed? 24b. Were eutopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Vital certifica director. 25. Was case referred to medical Be 26. Place of Death (Check only ona) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 2 No ot this 27. Menner of Death Certification: 28b. Time of 28d. Describe how injury occurred Division Attanding 5 Pending investigation 1 Naturel deeth. 1 Yes 2 No 2 Accident efter deet 6 Could not be determined 3 ☐ Sulcide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Spacify) 28f. Location (Street end Number or Rural Routa Number, City or Town, Stata) à 4 Homicide ò To the Hospital
within 24 hours of
To the Funeral Completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete and piace, and due to the ceuse(s) and menner es steted.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, deeth occurred at the time, dete end piece, and due to the cause(s) and manner stated. Medicai (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) MO DO051132 alya 30. Neme end address of person who completed cause of death (item 23a) (Type, Print) ABREGO, MEDICAL CNTR. DAFFIN LANE, DENTON MD 21629 JORGE 32. Registrar's Signature State

Registrar

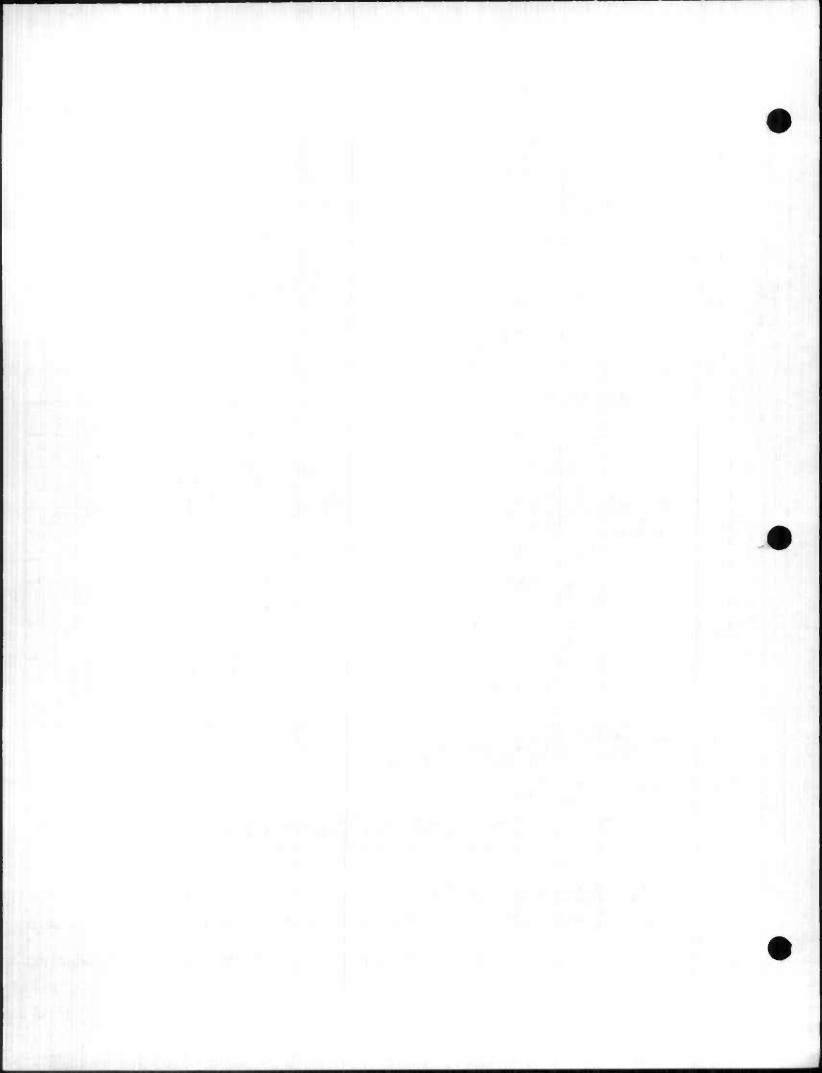
The second secon statism more than 2000 500 5 5 JUS

TO THE HOSPITAL OR ATTENDING PRYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

1 - STATE BEGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

_	REGISTRAR		CE	RHF	ICATE	OF	DEAL	I H	REG. NO				
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF OEATH			3. TIME OF DEATH	
	Edna Lo	ouise F	Iolland	1					July 24		99	12:45Am	
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last	birthday)	IF UNDER t	YFAR	IF UNDER	24 MDS	7. DATE OF BIRTH			PLACE (State or Foreign	
	256-74-2328	1 🗆 M 2 🖫 F	86	YRS.		DAYS	HOURS	MIN.	June II,	1012	Countr	ryland	
		A.		1110.						_			
	9a. FACILITY NAME (If not institution, give etr	reet and number)			9b. CITY, 1	OWN C	OR LOCATIO	ON OF OE	ATH	9c. COU	9c. COUNTY OF OEATH		
6	9333 Double Hills	Road			D	ent	ton			Ca	roli	ne	
DIRECTOR	RESIDENCE OF DECEDENT												
뿐	10e. STATE 10b. COUNTY			10c. CIT	r, TOWN OR	LOCAT	TION					10d. INSIDE CITY LIMITS?	
ō	Maryland Carol	ine		I	entor	1						1 TYES 2 NO	
7	10e. STREET AND NUMBER					101	. ZIP CODE	E		10a, CIT	IZEN OF Y	THAT COUNTRY?	
2	9333 Double Hills	Pond					2162	20				States	
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT			I The same								
교	1 Never Married 2 Merried	FORCES? 1	YES 2X N	O	13. W	NS DEC	ENDENT O	of HISPANI	C ORIGIN? (Specify Yes, Puerto Ricen, etc.)	or No-	14. RACE Black	— American Indian, L, White, etc.	
BY	3 ₩ Widowed 4 Divorced	IF YES, GIVE WI	R OR DATES				2 NO				Speci	ly:	
	A										Cau	casian	
=	15. DECEDENT'S EDUC (Specify only highest grade of	completed)	18e. DE0	CEDENT'S	USUAL OCC work done du e retired.)	ring mo	ON est of workin	ia.	16b. KINO OF BUS	SINESS/IN	DUSTRY		
9	Elementary/Secondary (0-12)	College (1-4 or 5+)	life.										
무	11 HS Grad. 3	years		Reg:	stere	ed :	Nurse	9	Medica	1			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)						18. MOTH	HER'S NAM	E (First, Middle, Melden	Sumame)			
	William Lee De	Ford						Mary	Edna M	ezic	k		
8	19a. INFORMANT'S NAME (Type/Print)		196	MAILING	ADDRESS /	Ctreat o	and Mumbar	or Brand D	oute Number, City or Tow	- Otata Zi	0-4-1		
2	Phyllis Smith	Sist							ad, Denton			21629	
		2120			-	_		2 1/00		_			
	20a. METHOD OF DISPOSITION  1 ☑ Buriel 2 ☐ Cremetion 3 ☒ Remo	val from State	20b. PLACE A cemetery, crer			ION (Na	ime of			CATION	City or To	wn, State	
	4 Donation 8 Other (Specify)		Blake	Ly Ce	emete:				7/30 B1	akel	y, Ge	eorgia	
- 3	21. SIGNATURE OF TUNERAL SERVICE LICE	ENSEE			22, N/	AME AN	ND ADDRES	SS OF FAC	Home, P.A			21.620	
	Detecale (	1. M	20025	2	1000							21629	
	- REVE				12	So	uth S	Secor	nd Street,	Den	ton,	Maryland	
	23. PART I. Enter the diseases, or co shock, or heart failure. L	omplications thei	caused the der	ith. Do n	ot enter th	ne mo	de of dyl	ng, such	as cerdiac or reapi	ratory sn	reat,	Approximate Interval Between	
	IMMEDIATE CAUSE (Final											Onset and Death	
	disesse or condition resulting in death)	M.t	- + -	1:	0	~ ~			- 4 17			>14-30 AT	
	resulting in death)	OUE TO (	OR AS A CONSEO	UENCE OF	):		5	019	ريان			711-30-11	
_		Oden	~ = = =	7 - 1	M F2-0	0 4	06	0+	Q. Q.			> 4-30-97 > 4-30-97	
CERTIFICATION	Sequentially list conditions, b.	DUE TO	OR AS A CONSEO	LIENCE OF	1 90 1	. 000	2 0	5 1	The sur	ng		717-30-11	
A	if any, leading to immediate cause. Enter UNDERLYING		J. 10 1 0011420	OLIVOL OF	,.					0			
2	CAUSE (Disease or Injury	DUE TO	22 10 1 000000										
E	that initiated events	DOE 10 (1	OR AS A CONSEO	UENCE OF	):								
E	d d	•											
	PART II. Other significant conditions	contribution to	la eth hus a et a		- 46 4	and the s				700	-		
EDICAL	- Suite symmetry conditions		ooth but not re	raulting i	n the und	eriying	g ceuse g	liven in F	Part I. 24s. WAS AN PERFOR		24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
ă		Pul. er	mpa	100	MA				1 🗆 YES 2	NO NO		COMPLETION OF CAUSE OF DEATH?	
				O								1   YES 2   NO	
-									_				
PHYSICIAN: M	25. WAS CASE REFERBED TO MEDICAL					28. PL	ACE OF D	EATH (Che	ok only one)				
8		HOSPITAL:			OTHER:		-						
<u>×</u>	27. MANNER OF DEATH	1   Inputient 2				_		_	Other (Specify)				
- 1		280. DATE OF I		28b. TIMI INJ	URY	WO	URY AT		28d. DESCRIBE HOW I	NJURY OC	CURED		
0		(Month, De			M	1 🗆 1	/ES 2	NO					
	1 Metural 5 Pending 2 Accident Investigation												
BY	1 Netural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF	INJURY At hon	ne, farm, s	treet, fector	y, office	•		281. LOCATION (Street &	ind Number	or Rural R	oute Number,	
ВУ	1 Netural 5 Pending 2 Accident Investigation	28e. PLACE OF	INJURY — At honite. (Specify)	ne, farm, s	treet, fector	y, office	•		281. LOCATION (Street a City or Town, Stete)	nd Number	or Rural R	oute Number,	
BY	1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined	28e. PLACE OF building, e	tc. (Specify)	. 20-1					City or Town, Stete)			oute Number,	
ВУ	1 Netural 5 Pending Investigation 3 Suicide 4 Homicide CERTIFIER (Check only	28e. PLACE OF building, e	tc. (Specify)	th occurre	d at the time	o, date	end place,	end due t	Olty or Town, Stete)  o the cause(e) end man	mer ee stat	ed.		
ВУ	1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined  29e. CERTIFIER (Check only)	28e. PLACE OF building, e	tc. (Specify)	th occurre	d at the time	o, date	end place,	end due t	Olty or Town, Stete)  o the cause(e) end man	mer ee stat	ed.		
COMPLETED BY	1 Netural 5 Pending Investigation 2 Accident 3 Suicide 4 Homicide 6 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER 29b. SIGNATURE AND TITLE OF CERTIFIER	28e. PLACE OF building, e  1AN: To the best of exa	ny knowledge, dea mination end/or in	ith occurre	d at the time	e, date	end place, eath occur 29c. LICE	end due t	City or Town, Stete)  o the cause(e) end mar ime, date end place, an	mer ee stat d due to th	ed. e cause(s	end manner ee steted. (Month, Day, Year)	
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BE COMPLETED BY	1 Netural 2 Accident 3 Suicide 4 Homicide  29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER  29b. SIGNATURE AND TITLE OF CERTIFIER  RESEARCH  30. NAME ANO AODRESS OF PERSON WHO	28e. PLACE OF building, e	ny knowledge, dea mination end/or in 	ith occurre	od at the timen, in my opin	e, dete	end place, eath occurs 29c. LICE D 17	end due to ded at the to the total at the to	o the cause(e) end mar ime, dete end place, an	iner ee steld due to the	ed. le cause(s) E SIGNED	end manner ee stated. (Month, Day, Year)	
BE COMPLETED BY	1 Netural 5 Pending Investigation 2 Accident 3 Suicide 6 Could not be determined 200. CERTIFIER (Check only one) 2 MEDICAL EXAMINER 200. SIGNATURE AND TITLE OF CERTIFIER ROBBERT W. 30. NAME AND ADDRESS OF PERSON WHO	28e. PLACE OF building, e  HAN: To the best of m: On the best of exa	ny knowledge, dea mination end/or in	th occurre westigatio	od at the timen, in my opin	e, dete	end place, eath occurs 29c. LICE D 17	end due to ded at the to the total at the to	City or Town, Stete)  o the cause(e) end mar ime, date end place, an	iner ee steld due to the	ed. le cause(s) E SIGNED	end manner ee steted. (Month, Day, Year)	
BE COMPLETED BY	1 Netural 2 Accident 3 Suicide 4 Homicide  29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER  29b. SIGNATURE AND TITLE OF CERTIFIER  RESEARCH  30. NAME ANO AODRESS OF PERSON WHO	28e. PLACE OF building, e	ny knowledge, dea mination end/or in	th occurre westigatio	od at the timen, in my opin	e, dete	end place, eath occurs 29c. LICE D 17	end due to ded at the to the total at the to	o the cause(e) end mar ime, dete end place, an	iner ee steld due to the	ed. le cause(s) E SIGNED	end manner ee stated. (Month, Day, Year)	



Please Type or Print in Black Indelibie Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death I Month 10:05 PM **Physician** Martha I. Johnson /Medical 4a Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Washington Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1□M 2√2 F Yrs. 85 Aug. 17, 1913 Director Pennsylvania 204-10-6726 Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Marvar show must be notified at NEWes 2□No Directo 28a-f Mercer Sharon 10e. Street and Number 10f. Zip Code 10g. Cifizen of What Country? ò 16146 Herns 23a 124 Wangler Avenue U.S.A. Funeral 12. Was Decedent Ever In U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No 1 Never Married 2 Married ò 1 Yes 2 XNo Specify: φ 3℃Widowed 4 Divorced White Year or Dates: "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygions. Wher than Elementary/Secondary (0-12) College (1-4or 5+) Education Teacher Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 8 and Mental marked Charles Ingalls Jessie Mann Stoop Pages 1 and 2 should 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If Nem 27 is 13534 Paradise Church Rd. Hagerstown, MD 21742 Charles F. Johnson altimore, 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Hillcrest Memorial Park 7/16/99 4 ☐ Donation 5 ☐ Other (Specify) Hermitage, PA 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Sample-0'Donnell Funeral Home, Inc. 555 East State Street Sharon, PA 23a. First the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, mock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final Acute disease or condition resulting in deeth) **Examiner** Due to (or as e consequence of): Examiner Lorund Astic Anerrym Iwack Rysbred The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attanding physician for use as the buria Physician/Medical Due to (or as a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the signed by the Postoperative Conjustive Heart Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Binknown þ 24b. Were autopsy findings available prior to should 24a. Was an autopsy Completed and my overlid Inferetion completion of ceuse of death? is certificata has 1 Yes 2 No 1 ☐ Yes 2 No Attending Physician: 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 phpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No this After this funeral c 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Naturei 2 Accident 5 Pending investigation death. 1 Yes 2 No Director: / 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) or A 4 Homicide 24 hours at Funeral D etely filled it Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. edical 29a, Certifier To the To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signeture and title of 038764 10

1 teges form mo

State Registrar 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

med. J

11110 32. Redistrar's Signature Compil Rd

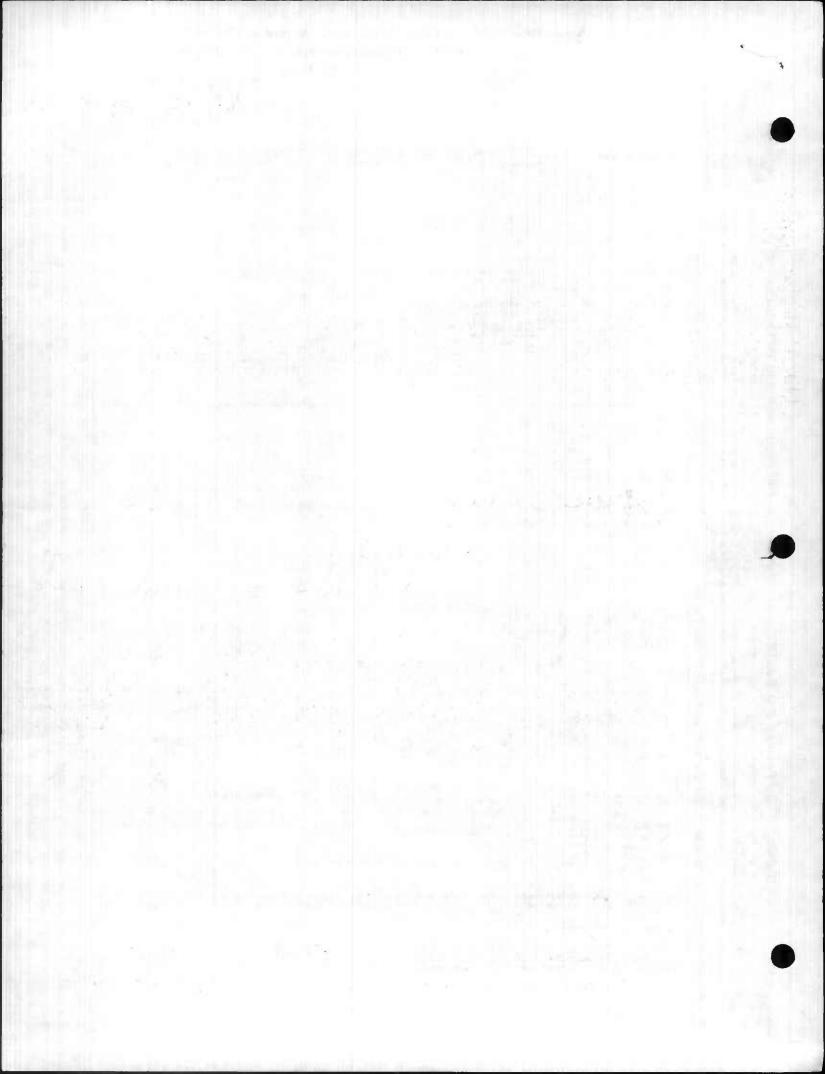
oak

5.2 100

P. RIGGE,

JUL 19 1999

31. Date filed (Month, Day, Year)



	Plea	se Type o										ble.	1056
		State	of Maryla		epartme Certifica			ind M	Mental H		ene 9	2	4356
ecedent's Neme (/	First, Middl	e, Last)	1 5 7	176					2. Date of				3. Time of Death
C	elda	Maria	Jensei						July	1	Day	Year 999	1:43am
Facility Name (If no				Д			4h City Toy	wo or 1	ocation of D		4c. County		
0 1-100													
		Hospital			If the	der 1 Year		thes				-	mery
ocial Security Num 17–24–374		6. Sex 1 □ M 2 <b>X</b> F	7. Age (In y	rs. last birth Yi	Month			Min.	(Month,	Day,	1923		nplace (State or Foreign untry) .bama
al Residence of De	ecedent												
na 10	0b. County	na	10c.	City, Town	or Location Vashin	gton,	D.C.						t0d. Inside City Limits Yes 2□No
. Street and Number	er				10f.	Zip Code				100	. Citizen of \	What Co.	untry?
		worth P	lace		, , , ,		0016			1.0	U.S		,
Maritel Status  1 □ Never Married  3 □ Widowed 4		ied 1 Yes		U,S.		cedent of pecify Cub	Hispenic Origon, Mexican Specify:	gin? (Sp , Puerte	pecify Yes or o Rican, etc.)	No-		ck, White	lcan Indian, b, etc. White
		t's Education st grade completed	d)	16a. E	Give kind of	sual Occu	pation during most	of wor	king	16	8b. Kind of B	usiness/l	ndustry
lementary/Seconda	ary (0-12)	College	(1-4or 5+)				sistan	t			Medi	cal	
Fether's Name (Fire Rueben		Last)							e Kel		iden Suman	ne)	
. Informent's Name	e/Relations	hip (Type, Print)		19b. I	Meiling Addre	ess (Stree	t and Numbe	r or Ru	ral Route Nu	m <i>ber</i> , i	City or Town,	Stete, Z	ip Code)
Jeri Jens	en-Mo	oran da	ughter	482	24 Par	k Ave	e., Be	the	sda, M	d.	20816		
. Method of Dispos 1 ☐ Burial 2 <b>1</b> C 4 ☐ Donation 5 [	Cremation		m State	cemetery,	Disposition (for crematory of c	r other pie		7.	Date /17/99		alls C		rown, State
Signature of Funer	ral Service	Licensee E. How	whole		Josep	h Gav		Soi		0 W	iscons	in A	ve. N.W.
a. Part1. Enter the c shock, or heart fe	diseese, or eilure. List	complications that only one cause or	t caused the de each line.	eeth. Do no	ot enter the m	ode of dy	ing, such as	cardiac	or respiretor	ry erres	t,	1	Approximate Interval Between Onset and Deeth
nediete Ceuse (Fin ease or condition ulting in death)	el	a			vere E	B. 2	sema						Years
(Specify lementary/Seconde 12) Fether's Name (Fir Rueben Informent's Name Jeri Jens Informent's Name Jeri Jens Informent's Name Jeri Jens Informent's Name Jeri Jens Informent's Name Jeri Jens Informent's Name Informent's Name Informent's Name Informent Informediate Ceuse (Fin basse or condition	only higher ary (0-12)  Faul ARelations Gen—Mo Cremation Other (S) ral Service disease, or allure. List	College  College  College  Last)  Lkner  hip (Type, Print)  Dran da  3   Removal from pecify)  Licensee	(1-4or 5+)  aughter 20t m State	482 D. Place of Ecemetery. Nation	Meiling Address  24 Par Disposition (Acrematory of the call Cr 22. Name Josep Washi	Lass (Street k Ave. Verme of a rother pice and Addr h Gav. ngton ode of dy	18. Mothe  My:  18. Mothe  My:  tand Numbe  2. Bei  3. Dry  ess of Facility wiler san, D.C.  ing, such as a	ra Nam rtle ror Ru the:	Kel Kel Route Nu Boda, M. Date  /17/99 as 513	ldie, Me	Medi  City or Town,  20816  C. Location  alls C  iscons	cal ne) Stete, Z City or 1	ip Code)  Fown, State  th, Va.  Approximal Interval Be Onset and

**Physician** /Medical Examiner

Examiner

Physician/Medicai

þ

Completed

Be

10

Certification:

Medical

attending physician and I for use es the bunel-trensit signed by the ail should should certificate has b director, To the Hospital or many within 24 hours after death.

To the Funeral Director: After this committeely filled in by the funeral dir

The law requires that the death certificate be executed

Hospital or Attending Physician:

Division of Vital Records, P.O. Box 68760.

Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

25. Was casa referred to medical exeminer?

1 Yes 2 No

27. Manner of Death

1 Natural

2 ☐ Accident

3 ☐ Suicide

29a. Certifier (Check only one)

4 Homicide

1. Decedent's Neme (First A

4a Facility Name (If not instit

5. Social Security Number

417-24-3747 Usual Residence of Deceder

10e. Street and Number

Elementary/Secondary (0-12 17. Fether's Name (First, Mic

21. Signature of Funeral Ser

Immediate Cause (Final disease or condition resulting in death)

homas 23a. Part1. Enter the disees shock, or heart feilure.

Rueben Fa 19a. Informent's Name/Rela Jeri Jensen-20a. Method of Disposition 1 ☐ Buriai 2 X Cremat

10a. State

Director

Funeral

by

Completed

Be 2 11. Maritel Status

**Physician** 

/Medical

**Examiner** 

**Funeral Director** 

permit. Peges 1 end 2 should be filed within 72 hours efter death with the Marylend Department of Heelth end Mental Hygiene.
Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic avent, the Medical Examinal must be notified and once.

Baltimore, Maryland 21215-0020

Due to (or es e consequence of): Due to (or as e consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary Artery Disease Gastrointestinal Bleeding

23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown X Yes 2 No

24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred

 Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 1X Certifying Physician: To the best of my knowledge, death occurred at the time, dete and plece, and due to the ceuse(s) and menner as steted. 2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date end plece, end due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

29b. Signeture and title of coci

5 Pending

investigation

6 Could not be determined

29c. License number Md. 42051

28c. Injury at Work?

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

28a. Date of Injury (Month, Dey Year)

D. Scott Cohen, MD 31. Date filed (Month, Day, Year) 1999

32. Registrar's Signature merca

1 Inpatient 2 □ ER/Outpatient 3 □ DOA

28b. Time of

5454 Wisconsin Ave. #1125 Chevy Chase, Md. 20815

State Registrar

3

near (S) of representative (12) A terffort payer the comment with the comment Tilliamin the Type Pour Co. 22 To The state of the s 

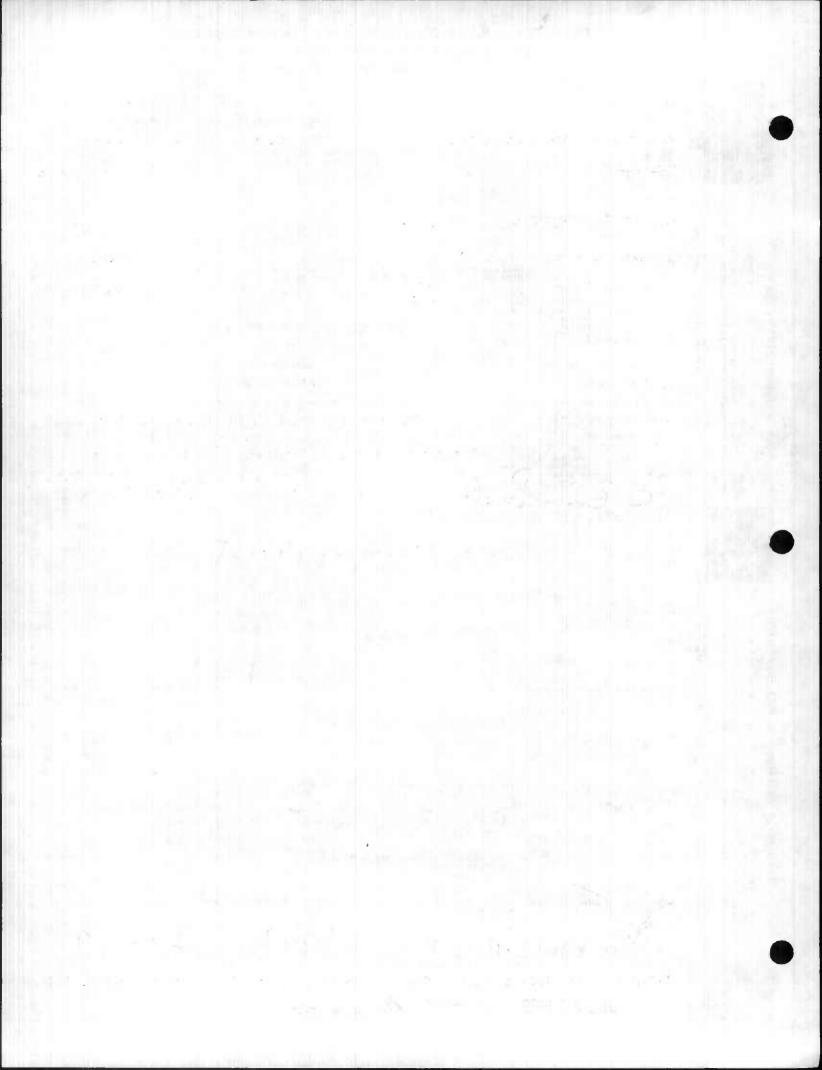
## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24357

									Death			Reg. No.			
	1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day Year											Veer	3. Tima of Death		
cian Iical	J	ohn J.	Jocus								July	17	19		5:50 AM
iner	4a	Facility Name	(If not institution, gi	ve street and r	num <i>ber)</i>				4b. City, To	wn, or Lo	ocation of Deat	h 4c. (	County o		
	G	enesis :	Eldercare	e - Spa	Creek				Annapo	olis		Anr	ne A	runde	21
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To Be		tonley		•/							vorawsk			-,	
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	H	azel Jo	cus / Wif	îe .		670 A	Ameri	cana	Dr. A	Apt.	21 Ann	apoli	is, l	MD 21	403
	20	a. Method of Dis	sposition  Cremation 3 l	Bemoval tron	n State	Place of Disp cemetery, cre	ematory or	other pla	_		/20/99			City or Tow	
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Registrar



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death Dav Month

**Funeral** Director 28a-f show 6 Name 23a b altimore, Maryland 21215-0020 Plebes 1 and 2 should be I nant of Health and Mental is marked Important: If item 27 any injury or other tra Department of

**Physician** /Medical Examiner

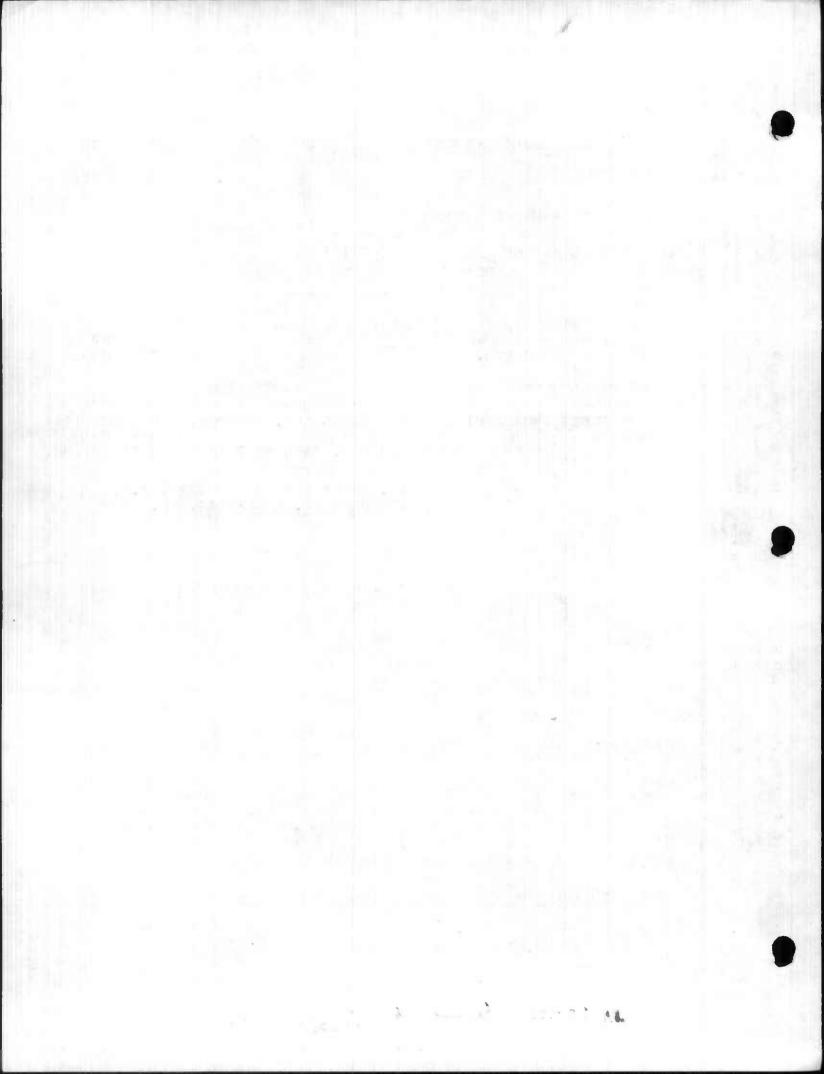
24358 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** ELENDA L. JONES 8 JULY 1999 2112 /Medical 4a Facility Name (II not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL If Under 1 Year 8. Dete of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) Hours Months 1□M 20 F Yrs. 040-28-4716 FEB. 8 1934 GEORGIA Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 NYes 2 No MARYLAND ANNE ARUNDEL CROFTON 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 늄 1455 HARWELL AVENUE 21114 US Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Rece - American Indian, Black White etc. 1 Never Married 2 Merried 1 ☐ Yes 2 No If Yes, Give 1 ☐ Yes 2 No Specify: Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) PRINCE GEORGE TEACHER 12th PUBLIC SCHOOLS 4 yrs. 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) 8 BENJAMIN LONDON MAGGIE ISOM 19e. Intorment's Neme/Reletionship (Type, Print) 19b. Meiting Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) EMERSON JONES (HUSBAND) 1455 HARWELL AVE. CROFTON, MARYLAND 21114 20b. Place of Disposition (Neme of 20s. Method of Disposition Date 20c. Location - City or Town, State ANNAPOLIS MEM. GARDENS 7/14/99 ANNAPOLIS MD. 1 Buriel 2 □ Cremetion 3 □ Removal from Stete 4 □ Donation 5 □ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name end Address of Facility WM. REESE & SONS MORTUARY, P.A. 23e. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory artest,

Approximate Interval Between Onset end Deeth

Approximate Interval Between Onset end Deeth BRAINSTEMCEREIROVASON AR ACCIDENT Immediate Cause (Final diseese or condition resulting in deeth) Central Nervous System VASculitus month Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or es a consequence ot) 68760 Physician/Medical the Due to (or as a consequence of): Box P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yea 2 No 3 Probably 4 Unknown Records. ρ 24b. Were eutopsy tindings available prior to completion of cause of deeth? Completed 24a. Was an eutopsy parlormed? 25. We case reterred to medical examiner 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital Hospital or Attending Physician: 8 26. Place of Deeth (Check only one) Hospitet: 12 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this funeral 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. tnjury at NA After 1 Neture 5 Pending investigation NA after death. MA 1 Yes 2 No 2 Accident NIA 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, term, street, tectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 Homicide within 24 hours a To the Funeral D completely filled edical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. 29e. Certifier (Check only one) To the 29b. Signeture and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Cenny LANSylex BUM 30. Name and address of parson who completed cause of death (Item 23a) (Type, Print) AMARDIS md 21401 OBBES St. #302 31. Date tiled (Month, Day, Year) 32. Registrar's Signeture State JUL 1 3 1999 Registrar

**DHMH 16 Ray 6/95** 



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death **Physician** 1939 FrAN CIS · /Medical 4a Facility Name (If not institution, give street and number) 4b. Cify, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 110 M 2□ F Months Yrs. Director 55 220-38-7819 Sept. 4, 1943 Maryland Usual Residence of Deceden the Maryland 10a State 10b County 10c. City. Town or Location 10d, Inside City Limits 7 is marked other than "naturel", or items 23s or 28s-f show traumstic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland | Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 34 Oak Court 21401 United States death Funeral 14. Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiane. I mortrant: If item 27 is marked other than "naturel", or item any Injury or other traumatic event 1 ☐ Never Married 2 ☐ Married Specify: White Saltimore, Maryland 21215-0020 1 Yes 2 No Specify þ 3 Widowed 4 Divorcad Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) TV Repair 11 Service Technician 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Charlotte E. Tydings George C. Jones, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Audrey L. Sheets / Sister 11 Hill Street Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 7-13-99 Hillcrest Cem. Annapolis, MD. 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licen 147 Duke of Gloucester St Annap., Md 21401 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsel and Death **Physician** /Medical Immediate Ceuse (Final years disease or condition resulting in death) Examiner Examiner and burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of): certificate be axec physician Physician/Medical the Due to (or as a consequence of): Ses 980 0 23b. Did tobacco use contribute to the cause of death? ed by the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 1 Yes 2 No 3 Probably 4 Unknown signed t Records, p 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed peen 1 Yes 2 No 1 □Yes 2 □ No certificate Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2ZWo 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Natural 2 Accident 5 Pending Investigation after death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Funeral 29a. Certifier (Check only one) edical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the To the To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c. License number 0 hild address of person who completed cause of deeth (Item 23e) (Type, Print) 30. Name A 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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State of Maryland / Department of Health and Mental Hygiene

		Certificate of	Death	R	eg. No.	9 24360
1. Decedent's Name (First, Middle, L	est)			2. Date of Dea Month		3. Time of Death
cian EUSEBIA SILVA	RIVERA JONES			July		8:35 AM
iner 4a Facility Name (If not institution, gi			4b. City, Town, or L	ocation of Death	4c. County	of Death
Holy Cross Hosp	ital		Silver S	pring	Montg	omery
5. Social Security Number 6.	Sex 7. Age (In yrs. las	Montha Days	If Under 24 Hrs.	8. Date of Birth (Month, Day	Year)	Birthplace (State or Foreign Country)
r 579-24-3583	1□M 2MF 90	Yrs.		FEB. 10	, 1909	PUERTO RICO
Usual Residence of Decedent  10a. State 10b. County	10c City	Town or Location				10d. Inside City Limits
						1 ☑ Yes 2 ☐ No
MD. MONTGO	MERY	SILVER SPR	ING		0. 000. 411	41
		10f. Zip Code			0g. Citizen of W	rnat Country?
b	HAMPSHIRE AVE.		0904			S.A.
11. Marital Status	12. Was Decedent Ever in U,S. Armed Forces?	13. Was Decedent of I If Yes, specify Cub	an, Mexican, Puerto	o Rican, etc.)		k, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yea 2 ☒ No If Yes, Give Year or Dates:	1 No 2 No	Specify: TOT TO	RTO RICA	Specify.	WHITE
		16a. Decedent's Usual Occur		VIO VICE	16b. Kind of Bu	
(Specify only highest gi	ade completed)	(Give kind of work done life. DO NOT use retire	during most of worl	king	TOD. KING OF DU	sinesamoustry
15. Decedent a E (Specify only highest gi Elementary/Secondary (0-12) UNK.	College (1-4or 5+)	HOMEMAK			н	OME
	()	11 CA-MINITALL	18. Mother's Nem	ne (First, Middle, I		
17. Pather's Name (First, Micole, Las	SILVA				ਸਟਾ	RADA
19a. Informant's Name/Relationship	1	19b. Mailing Address (Street	t and Number or Bu	ral Route Number		
JOHN A. RIVERA/					MD. 208	
20a. Method of Disposition	20b. Pla-	ce of Disposition (Name of	040	-		City or Town, State
1 ☐ Burial 2 ☐ Cremation 3 [	_Hemoval from State	netery, crematory or other pla		-11		
4 Donation 5 Other (Spec	1 1 1	. LINCOLN CEM		7/20/99	BIRIDINA	WOOD, MD.
21. Signature of Funerat Service Lor	1.0	22. Name and Addre	ess of Facility			
M.M. Char	MOOO!					RDALE, MD. 2073
23a. Part1. Enter the disease, or cor shock, or heart feilure. List only	nplications that caused the death. one cause on each line.	Do not enter the mode of dyi	ng, such as cardiac	or respiratory arr	est,	Approximate Intervat Between
						Onset and Death
Immediate Cause (Finel disease or condition resulting in death)	Anoxic End	ephalopathy				
	Due to (or a	is a consequence of):				
Sequentially list conditions, if any, leading to immediate cause. Enter Underfying	Aspiration	Pneumonia				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or a	is a consequence of):				
cause. Enter Underlying Cause (Disease or injury	c. Seizure Di	sorder				
Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	s a consequence of):				
	d					
Part II. Other significant conditions  Congestiave He	contributing to death but not resulti	ing in the underlying cause gi	ven in Part I.			ntributa to the causa of death?
	eart Failure			1 U Y	as 2 No	3 Probably 4 Unknown
3				24a. Was 6	n autoneu	24b. Were autopsy findings
Renal Insuffic	iency; Anemia ,			perfor		available prior to completion of cause
			- 5-10			of death?
Dementia  25. Was case referred to medicat				1 U Y	es 2 No	1 ☐ Yes 2 ☐ No
25. Was case referred to medicat examiner?	H			th (Check only or	ne)	
1 ☐ Yes 2 ☐ No		VOUDATION 3LI DOX		ome 5 Resid		
27. Manner of Death 1 ØNatural 5 Pending	28a. Dete of Injury (Month, Day Year)	8b. Time of lnjury 28c. tnju Wo		28d. Describe h	ow injury occurr	ed
2 Accident investigation 3 Suicide 6 Could not	~		Yes 2 No			
27. Manner of Death 1 ØNatural 2 \ Accident   5 \ Pending   1 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	28e. Plece of Injury - At hom building, etc. (Specify)	e, farm, street, factory, office		28f. Location (S City or Town	treet and Numb n, State)	er or Rural Route Number,
(Check only 2 Medical Exa	hysician: To the best of my knowle miner: On the basis of examination	edge, death occurred at the ti	me, date and place,	, and due to the c	ause(s) and ma	nner as stated. and due to the cause(s)
	and manner stated.					
29b. Signature and title of certifier	M	29c. Licens	se number	- 2	rad. Date signed	i (Month, Day, Year)
	X / Yusens	m) D51	.083		July 1	5, 1999
30. Name and address of person who		3a) (Type, Print)				
Yisa O. Yussuf		llage Park Dr	ive, Gree	nbelt. M	D 20770	
e 31. Date filed (Month, Day, Year)	32. Begintrar's Signatur	re /				
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. Amended #18, 7/22/99, T.M. Kent Co. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month Dey **Physician** ODETTE ANNETTE 1999 JULY 17 2050 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner KENT & QUEEN ANNE'S HOSPITAL CHESTERTOWN | If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) | October 29, 1 5. Social Security Number 7. Age (In yrs. last birthdey) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 N F Months Yrs. 242-86-6936 46 Wisconsin Director Usual Residence of Decedent the Maryland 10b County 10c. City, Town or Location 10d, Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Maryla Depertment of Health end Mental Hydene. Important: if item 27 is marked other than "natural", or itema 23a or 28a-f show any Injury or other traumatic event, the Medical Examinet must be notified and. 1 Yes 2 No Directo Maryland Queen Anne's Millington 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 200 Squires Lane 21658 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bieck, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White by 3 Widowed 4 Divorcad 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Educetion (Specify only highest grede completed) College (1-4or 5+) 2 Elementary/Secondary (0-12) Homemaker Own home 18. Mother's Name (First, Middle, Maider Surname) Roseileen Alder -Rosaline-Alder-17. Fether's Name (First, Middle, Last) Frank Gillin 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Pierson C. Jones, Jr./Husband 200 Squires Lane, Millington, Maryland 21651 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Date 20c. Location - City or Town, Stete 1 Burlal 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) Wesley Chapel Cemetery 7/21/99 Rock Hall, Maryland 21. Signeture of Funeral Sprvice Licensee 22. Name end Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

130 Speer Road, Chestertown, Maryland 21620
Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final BREAST CANCER METASTATIC diseese or condition resulting in death) Examiner Examiner physicien and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immediate ceuse. Enfer Underlying Cause (Disaase or Injury that initiated evants resulting in death) Lest Due to (or es e consaquence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by the s should be deteched 1 Yes 2 No 3 Probably 4 Unknown ò 24b. Wara autopsy findings evailable prior to completion of ceuse of deeth? Completed 24a. Was an autopsy ils certificate hes l director, page 2 s 1 ☐ Yes 2 No 2 No 1 Yes Hospital or Attending Physician: Be 25. Was cese referred to medicel examiner? 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes ZENo Certification: To Inpatient 2 ER/Outpetlent 3 DOA this funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Naturel 2 ☐ Accident 5 Panding 1 ☐ Yes 2 ☐ No Investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 4 Homicida

To the Hospital or Attendir within 24 hours efter deeth. To the Funeral Director: Al completely filled in by the fu

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Registrar

29a. Cartifiar

29b. Signature and title of certifier

30. Neme end eddress of person who completed cause of death (Itam 23a) (Type, Print)

Helen A. Noble, 122 Speer Road, Suite 5, Chestertown, Maryland 21620 32. Registrar's Signeture 31. Date flied (Month, Dey, Yeer) souls JUL 2 0 1999

Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, end due to the cause(s) and manner as stated.

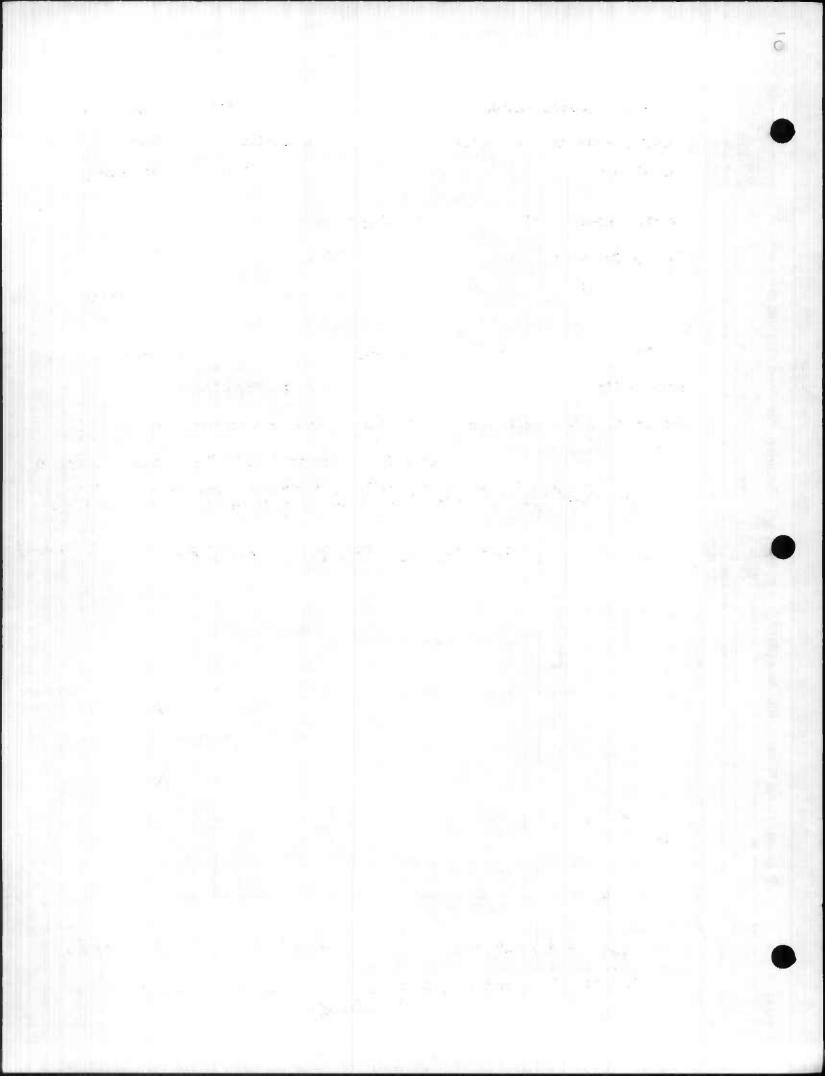
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D41587

29d. Date signed (Month, Dey, Year)

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### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ( Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Richard Carl Johnson 8:37 AM 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Death Southern Maryland Hospital Center Clinton, MD Prince George 6. Sex 1**X** M 2□ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jun 8, 9. Birthplace (State or Foreign Country) W. Chester, PA 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours Min 70 Yrs. 1929 194-20-8122 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ¥XYes 2□No MD Bowie Prince George 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 14405 Dunstable Court United States 20721 14. Race · American Indian, Black, Whita, atc. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 X Yes 2 □ No If Yas, Give Yeer or Dates: 2-13-51 1 Never Married 2 Married 1 ☐ Yes 💀 No Specify: SpecifyAfrican American 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Rusinass/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) Medical Nurse 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father'a Name (First, Middla, Last) Hattie Washington Unknown 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14405 Dunstable Court Bowie, MD 20721 Susanne Johnson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Bunel 2 Cremation 3 Removal from Stete Rolling Green Mem. Park 7/15/99 West Chester, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility DeBaptiste Funeral Homes, Inc. 21. Signature of Funeral Service Licenses Worthington & Miner Sts. West Chester, Pa 19382 Lale Buy 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death DISTRESS SYNDROME 2 MONTHS ADULT RESPIRATORY Immediate Causa (Final disease or condition rasulting in daath) MULTIPLE MYELDMA Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Causa (Disaase or injury that initiated events resulting in death) Last SEPSIS Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part t. 1 Yes 2 No 3 Probably 4 Unknown 24b. Wera autopsy tindings available prior to 24a. Was an autopsy parformed? completion of ceuse of death? 1 Yas 2 No 1 TYes 2 No 25. Was cese referred to medical axaminar? 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 DUNO 1 Inpatiant 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Denatural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide 12 Certifying Physician: To the best of my knowledga, deeth occurred at the tima, date and place, end due to the causa(s) and manner as stated. 29a. Certifian (Check only 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, end due to the ceusa(s) and manner stated. 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) D43346 MI

State Registrar

/Medical

Examiner

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Funeral

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Completed

**Funeral** 

Director

item 27 is marked other than "naturel", or itema 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "naturel", or iten any injury or other traumatic event, the Medical Examinations.

**Physician** 

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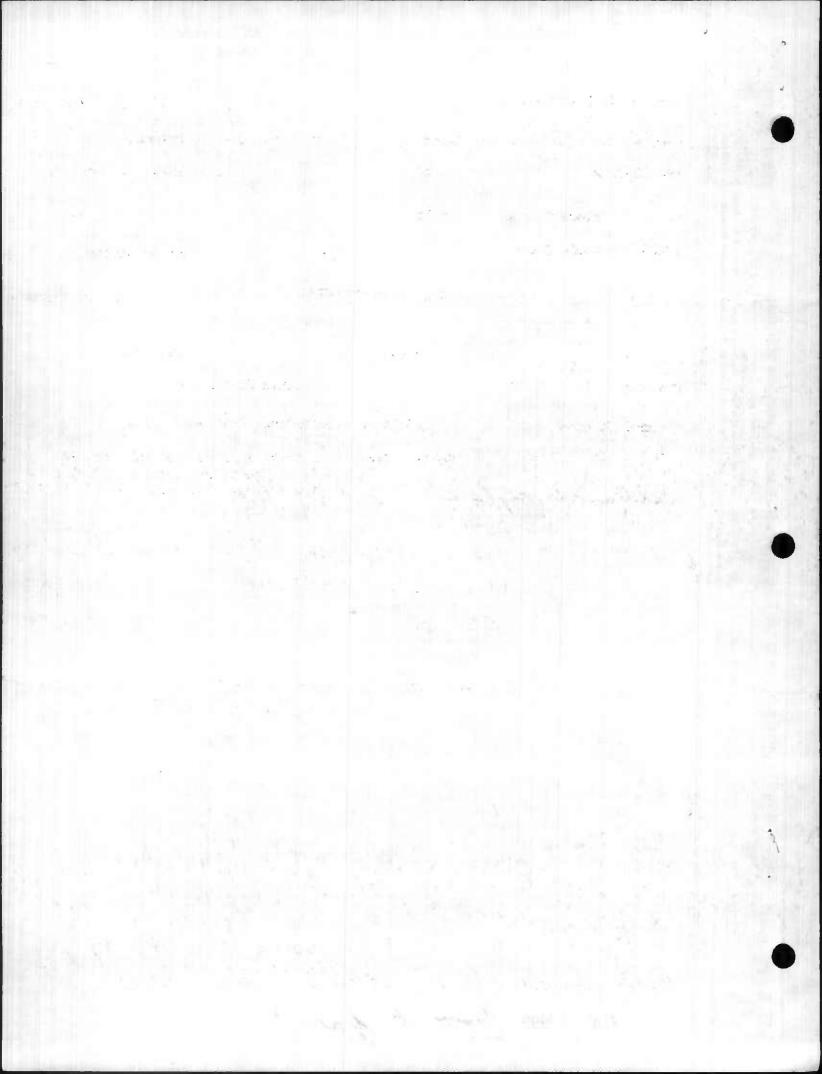
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State of Maryland / Department of Health and Mental Hygiene 9 9 24363

			C	ertificat	e of L	Death			leg. No.	-	7000		
<b>5</b> 1	1. Decedent's Nema (First, Middle,	Last)						2. Date of Dea		Voer	3. Time of Death		
Physician /Medical	Wilhelmina	Kunis							15, 199		4:00 p.		
Examiner	4a Facility Name (If not institution,	give street and number)			4	b. City, To	wn, or Lo	cation of Death	4c. County o				
	Genesis Elderca	re - Spa Cre	ek			Ann	apol	is	Anne	Arur	ndel		
Funeral Director	5. Social Security Number 141–54–1433	4DM ONE	(In yrs. last birtho	Months	1 Year Days	If Under Hours		8. Data of Birti (Month, Da)	Year)	9. Birthp	place (Stata or Fore		
	Usual Residence of Decedent		72					Aug 13,	1906 IN	ew J	ersey		
ž u	10a. State 10b. County		10c. City, Town o	r Location						1	Od. Inside City Lin		
5 5	MD Anne Ar	undel	Arnold								1 ☐ Yas 2 [		
S 82	10e. Street and Number			10f. Zip	Code				log. Citizen of Wi	hat Cour	ntry?		
r hems 23s or 28s-fe orest mest be notified Funeral Director	229 Via Dante D	rive			210	12			USA				
ene. than 'natural', or flems 23s or 28e-f show the Medical Examiner must be notified at ompleted by Funeral Director	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U,S.	13. Wes Deced	ent of Hi	ispanic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)					
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than the	Elementary/Secondary (0-12)	College (1-4or 5+	}	ive kind of wo		)	t bi work.	9					
Hygien ther the ent, the	6		HOI	nemaker					Home		La Lace		
d other than event, the Me Be Comp	17. Father's Name (First, Middle, La	ist)							Maiden Sumama	3. Time of Dea 4:00 p. 4:00 p. of Death Arundel  9. Birthplace (State or Focurity) New Jersey  10d. Inside City Li 1 Yes 2  What Country?  2a - American Indian, ck, White, etc.  White  usiness/Industry  2b City or Town, State Irlawn, NJ  Ck Funeral Ho ark, MD 21146  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  3 Probably 4 Unk  24b. Ware autopsy finding available prior to completion of cause of death?  1 Yes 2 No  Noter (Specify) Tred  and (Month, Day, Year)  and (Month, Day, Year)			
	Tunis Bos					Marga	aret	Van Dyke					
th and Mental Hygle 7 is marked other to treumatic event, to To Be Co	19a. Informant's Neme/Relationship	(Type, Print)	19b. M	lailing Address	(Street	and Numbe	er or Aura	I Routa Numbe	r, City or Town, S	State, Zip	Code)		
27 is	Margaret DeYoung	/daughter	229	Via D	ante	Driv	re. A	rnold,	MD 210	12			
Nem 27 i	20a. Method of Disposition		20b. Place of D	isposition (Nan	na of		1	Dete			own, State		
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Within 2 To the Complet	one)	and manner state	ed.										
100 A	29b. Signature and title of certifier					e number	2.						
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	30. Name and address of person with	to completed cause of dea	ath (Item 23a) (Tv	pe, Print)					7/161				
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State Registrar	JUL 20	1999	مدس	b. 1	200	41							

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### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death July 19, 1999 Dorothy Omelia King 7:38 A.M. 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 1 M 2 F Days Months Yrs. Jan. 19, 1929 Washington, 578-34-3973 70 Usual Residence of Decedent 10h. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Anne Arundel Edgewater 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21037 USA 301 Fairlea Road 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 [Δ] No If Yes, Give Year or Dates: 14. Rece - American Indian, Black, White, etc. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Nomerried Specify: White 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Office of the Elementery/Secondary (0-12) College (1-4or 5+) 10th Comptroller of Treasury Clerk 17. Father's Neme (First, Middle, Last) 18 Mother's Neme (First Middle Maiden Sumame) Daniel S. Walker Susie America 19e. Informant's Neme/Retetionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 301 Fairlea Road Edgewater, Maryland 21037 Jack D. King/ Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town. Stete 1 X Burial 2 Cremetion 3 Removel from State Lakemont Meml. Gardens 7-22-99 Davidsonville, MD 4 ☐ Donation 5 ☐ Other (Specify) Alco Lif 21. Signature 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximeta Interval Between Onset end Deeth Immediate Cause (Final disease or condition resulting in death) . Myocardial Infarction Minutes Due to (or as a consequence of) Lung Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Emphysema Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? to Yes 2□ No 3 Probably 4 Unknown 24b. Wara autopsy tindings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No

**Physician** /Medical Examiner

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death.

The law requires that the death certificate be executed

Box 68760.

P.O.

Division of Vital Records,

Attanding Physician:

**Physician** 

/Medical

Examiner

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Funeral

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**Funeral** 

Director

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Department of Important: If any injury or once.

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altimore, Maryland

Pages 1 and 2 should

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Examiner buriel-tran Physician/Medical the 65 usa signed by the a þ Completed pege 2 funeral director. Be Certification: To To the Hospital or Attendit within 24 hours after death.
To the Funeral Director: A completely filled in by the fi

25. Wes case reterred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28h. Time of 28c. Injury at Work? 5 Pending investigation 1 Netural 1 TYes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide

(Check only one)

29e. Certifier

1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie

29c. License number

29d. Date signed (Month, Day, Year)

Wathing

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jeffrey Atkinson, M.D.

470-D Ritchie Hwy. Severna Park, MD 21146

State Registrar

Medical

31. Date filed (Month, Day, Year) JUL 2 0 1999

32. Registrar's Signature

2001 0 5 JUL

Please Type or Print in Black indeiibie ink. Assure All Copies Are Legibie. and State of Maryland / Department of Health and Mental Hygiene 7/14/99 mcg Certificate of Death AACO Health Dept 2. Dete of Death **Physician** Grace Josephine Klimkiewicz 10, 1999 July 2:00 am /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2024 Gov. Thomas BLaden Way #104 Annapolis Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year Months Days If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 6 Sax Birthplace (State or Foreign Country) Funeral 78 Yrs. 578-18-9765 Director June 25, 1921 Washington, DC Usual Residence of Deceden 10a State 10h County 10c. City. Town or Location t 0d. Inside City Limits Name 23a or 28a-f above the must be notified at MD Anne Arundel Annapolis 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? deeth with 2024 Gov. ThomasBLaden Way #104 21401 USA Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11 Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. pemit. Peges 1 and 2 ahould be filed within 72 hours after of Department of Hastin and Mental Hygiene. Important: if Item 27 is marked other than "natural, or Item eny Injury or other traumatic evant, the Medical Exemples. 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: PV 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Home 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) B Marguerite Malloy Molloy Hugh McCann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Marie Speaker / daughter 2024 Gov. ThomasBLaden Way #104, Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete July 13 DE Burial 2 ☐ Cremetion 3 ☐ Removel from State Washington, DC 4 ☐ Donation 5 ☐ Other (Specify) Mount Olivet Cemetery 1999 21. Signature of Fugeral's 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart feiture. List only one cause on each line. Approximete totervel Between Onset and Deeth Physician /Medical Immediate Cause (Final disease or condition resulting in death) 2 years Examiner Examiner physicien end the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760 Physician/Medical Due to (or as a consequence of): P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Records. by 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24e. Wes an autopsy performed? page 2 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No certificate Division of VItal or Attanding Physician: 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Attac 1 (INaturat 5 Pending An Hospital or .

"In 24 hours effer des.

"nevel Director: AP death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide in 24 hour. Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s), and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier unter 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Annapolis ms 21401 m.O 600 Ridgely Avr 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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State of Maryland / Department of Health and Mental Hygiene

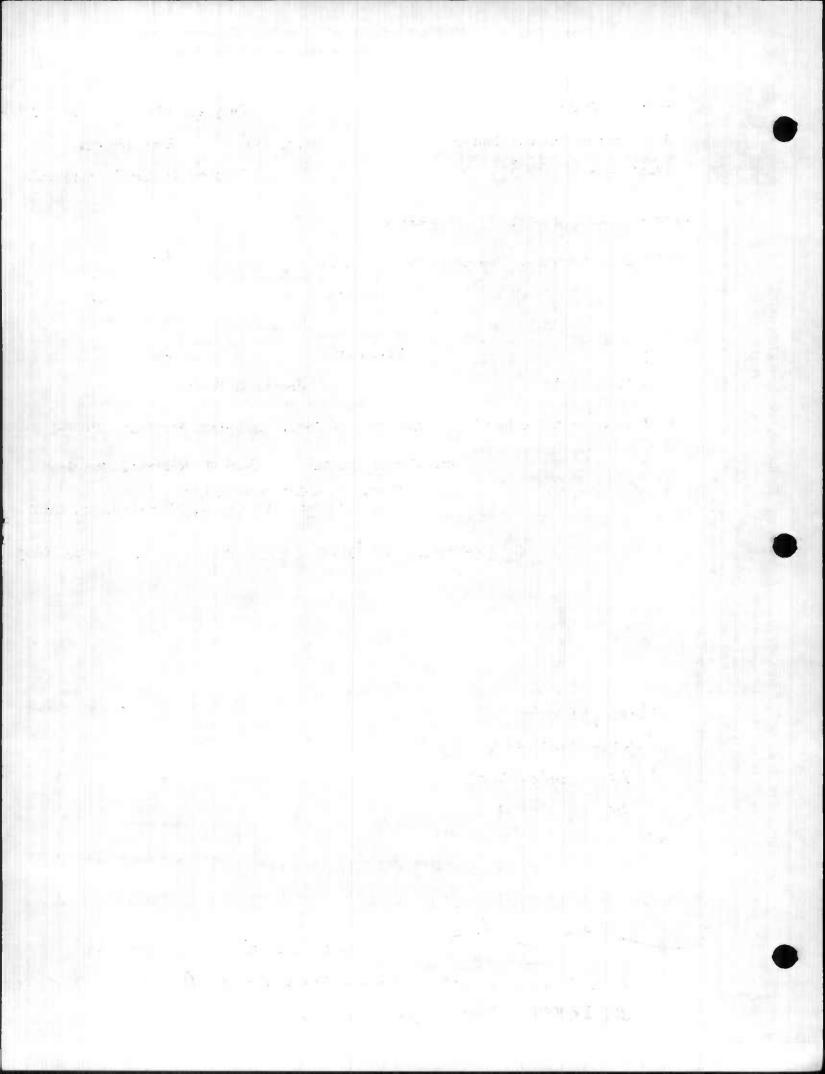
24366 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Frank J. Kirchner, Sr. 9:30 PM 10 1999 July /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Annapolis
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Genesis Eldercare - Spa Creek Ctr. Anne Arundel 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1⊠M 2□F Months Director 214-05-2749 85 May 13, 1914 Maryland Usual Residence of Deceden 10a State 10c. City. Town or Location 10b. County 10d. Inside City Limits show 1 Yes 2 No must be notified Anne Arundel Director MD Annapolis 280-1 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or flama 23a or 1954 Severn Grove Road 21403 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 72 hours after 1 Never Married 2 Married altimore. Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: À Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) Cotlege (1-4or 5+) permit. Papes 1 and 2 should be filled w. Department of Health and Mental Hygien (important). If them 27 is marrised other the any Injury or other transmission. Heavy Equip. operator Construction 18. Mother's Name (First, Middle, Meiden Surname) 17 Father's Name (First Middle Last) Be Catherine Polk John Kirchner 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Louise Kirchner / wife 1954 Severn Grove Rd. Annapolis, MD 21403 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Durlal 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 7-13-99 Hillcrest Cemetery Annapolis, MD 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signature of Funeral Service Licenses buel 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final scleropic 6M disease or condition resulting in death) Examiner Examiner Constitue physician and the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. that the death certificate be Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 3 1 Yes 2 No 3 Probably 4 Unknown signed t P 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy peeu 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 25 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) ne Hospital or Attending Ph n 24 hours after death. ne Funeral Director: After th 27. Manner of Death 28d. Describe how injury occurred 28b Time of 28c. Injury at Work? Certification: 1. Netural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Sulcide 28e. Placa of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 Homicide \*\*Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 8 29c. License number 03263 G 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifie Lo 30. Name and address of parson who completed cause of death (Item 23a) (Type, Print) 21081) Chip My Drive 32. Registrar's Signature State 1 4 1999 Registrar

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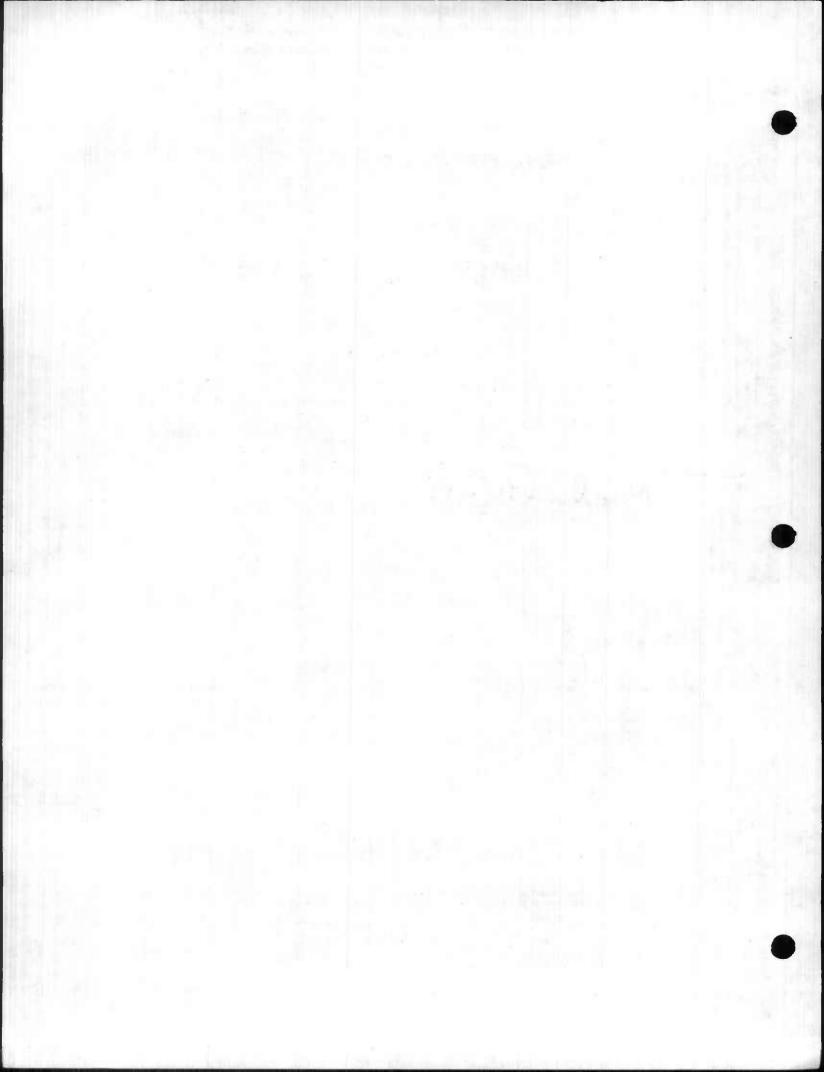
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7/19/99 CMH AAC	O HEALTH D	<b>EPT</b> Certific	ate of Dea	th	Reg. No.	24301
1. Decedent'a Nama (First, Middla, Last)					of Death	3. Time of Death
Edith Kraft	treet and number)		4b. City.	July	13, 1999	12:55 A.M
5. Bogiat/Security Number 0 6. Sax	7. Aga (In yrs.		der 1 Yeer   if Und	der 24 Hrs. 8. Data o	of Birth	Birthplaca (Stata or Foraign Country)
Usual Rasidance of Decedent	10c C	ity Town or Location				10d. Insida City Limits
						1 ☐ Yes 2 ☑ No
10e. Street and Number	idei Ed		Zip Coda		10g. Citizen of V	Whet Country?
225 Maryland Avenu	o Edeouetem	Ma	21027		USA	
11. Meritel Stetus	2. Wes Decedant Evar in U	J.S. 13. Wes De	cedant of Hispanic	Origin? (Specify Yes o	or No- 14. Rac	a - Amarican Indian, k, White, atc.
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Ellis S. Lewis			Je	essie I. Mo	ohler	
		19b. Mailing Addr	ess (Street and Nu	mber or Rural Routa N	umber, City or Town,	Stata, Zip Coda)
	Husband)	225 Mary	land Ave.		er, Maryla	nd 21037-1560
1 Deurial 2 □ Cramation 3 □ R	emoval from Stata	cematary, cramatory	or other place)	Deta	200. Location -	City of Town, State
	Ft	. Lincoln	Cemetary	7-16-9	9 Brentwo	od, Maryland
/ /		0	D 77 =	-	Home	
23a Farth Enter the disease, or compli	cations that caused the dea	th. Do not entar than	Solomons	Island Ros	d Edgewa	ter, Md 21037
shock, or heart failura. List only on	e cause on each line.	an and the state of the state o	in the state of th		.,	Intarval Batween Onset end Daeth
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Part II. Other significant conditions con	ributing to death but not re	sulting in the underlying	o causa givan in P	art I. 23b.	Did tobacco use co	ntribute to the cause of death?
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OSTEUPOR	2120					24b. Wera autopsy findings available prior to completion of cause
11.1						of death?
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axaminar?	ospital:		Othor			
27. Manner of Death	28a. Data of Injury		DOA   4L			
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3 Suicida 6 Could not be datamined	28a. Placa of Injury - At Inbuilding, atc. (Speci	noma, farm, straat, fac fy)	tory, office			per or Rural Routa Number,
(Check only 2 Medical Examin	er: On the basis of axamina					
	and mannar stated.		29c. Licansa numb	per	29d. Data sinne	d (Month, Day, Year)
hu				4	T. 1. 1:	2 1999
			00032		7019	2,1111
30 Name and address of coresn ut-	notated cause of death fire	m 23s) (Time Drink)				
30. Nama and addrass of person who con	mpleted cause of daath (Ite		RIDGEL	Y AVELINE	ANNAS	POUS, MD 21401
	Edith Kraft  4e Facility Nema (If not institution, give is Anne Arundel Medit is give in a first in the facility Number 200   6. Sex 217 14 6220   1	Edith Kraft  4e Facility Nema (If not institution, giva street and number)  Anne Arundel Medical Center  5. Sociat/Secqrity Number 00  217-14-6220  Usual Rasidance of Decedent  10a. Stata  10b. County  Maryland Anne Arundel  10c. Street and Number  225 Maryland Avenue Edgewater  11. Meritel Status  1 Never Merried 2 Married  3 Widowed 4 Divorced  15. Dacedant's Education (Spacify only highest grada completed)  Elementary/Secondary (0-12)  17. Fathar's Neme (First, Middla, Last)  Ellis S. Lewis  19a. Informant's Name/Relationship (Type, Print)  Charles A. Kraft (Husband)  20a. Mathod of Disposition  1 Daulal 2 Cramation 3 Removal from Stata  4 Donation 5 Other (Specity)  21. Sonature of funeral Service Licensys  22a. Part Enter the disease, or complications that caused the deal and the cause. Final disease or condition rasulting in death)  Dua to (  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Content Underlying Cause, Content Underlying Cause, Content Underlying Cause. Enter Underlying Cause, Content Content	Edith Kraft  4e Facility Nema (If not institution, give street and number)  Anne Arundel Medical Center  5. Byogar/Security Number (1) 6. Sex 1 1 M 2X F 7. Age (In yrs. last birthday) 1 Month (217 14 6220)  Usual Residence of Decedent 100. Stata 100. County Maryland Anne Arundel Edgewater  10e. Street and Number 10. Stata 100. County Maryland Anne Arundel Edgewater  11. Martiel Stetus 11. M	Edith Kraft  46 Facility Name (If not institution, give street and number)  Anne Arunde1 Medical Center  5. Sepatage-spip Number 200 6. Sex 10 M 20 F 80 Yrs. Sex birthday)  10. State 1 106. County  Maryland Anne Arunde1 Edgewater  106. Street and Number  106. Street and Number  107. Street and Number  108. Street and Number  109. Street and Number and Nu	Bedith   Kraft   Application of the property	Edith Kraft  46 Fability Name (India institution, give street and number)  Anne Arrunde I. Medical Center  5. Seguand Secretary Number (10 Center)  5. Seguand Secretary Number (10 Center)  5. Seguand Secretary Number (10 Center)  5. Seguand Secretary Number (10 Center)  5. Seguand Secretary Number (10 Center)  5. Seguand Secretary Number (10 Center)  5. Seguand Secretary Number (10 Center)  5. Seguand Secretary Number (10 Center)  5. Seguand Secretary Number (10 Center)  5. Seguand Secretary Number (10 Center)  5. Seguand Secretary Number (10 Center)  5. Seguand Secretary Number (10 Center)  5. Seguand Secretary Secret



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			State of Mar		ertificate of	Death		eg. No. 9	) 2	4368
	Physician	1. Decedent's Name (First, Middla, La:	st)				2. Data of Deat Month		Year	3. Time of Death
	/Medical	Anita		Kearney			July 18			5:28pm
	Examiner	4a Facility Name (If not Institution, give				4b. City, Town, or Lo	cation of Death	4c. County	of Death	
		9704 Sunset Drive 5. Social Security Number 6. S		(In yrs. last birthday		Rockv111e	D Date of Birth	Monte		
	Funeral Director		□M 2⊠F	63 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, July 5,		Gern	ace (Stata or Foreign ry) nany
	D Bu	10a. State 10b. County	1	Oc. City, Town or L	ocation				10	d. Inside City Limits
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	with the Marylar a or 28a-1 show be notified at Director	10e. Street and Number			10f. Zip Code		10	0g. Citizen of W	hat Count	ry?
	Seath w ms 23s imust b	9704 Sunset Drive	e		208			United		
Maryland 21215-0020	at, or the Examination	11. Marital Status  1 □ Naver Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1  Yas 2 No If Yes, Give Yaar or Datas:	ar in U,S. 13.	Was Decedent of H If Yas, specify Cub 1 ☐ Yas 2 ☑ No	dispanic Origin? (Spe an, Mexican, Puarto Specify:	cify Yas or No- Rican, atc.)		- America k, Whita, e	rtc.
5-0	72 hour dical Ex	15. Decedent's Ed	fucation	16a. Deci	dent's Usual Occup	pation during most of worki	00	16b. Kind of Bus		
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	and 2 salth at n 27 is ser trau	William R. Kearney	The same of the sa			rive, Rocl				
re,	-756	20a. Method of Disposition		20b. Place of Disp				20c. Location - (		
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Baltimore,	1 3 2 4	at Cignutura of Funarel Sarvice Licen			2. Nama and Addra	es of Encility	Vol Fune			
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	/Medical Examiner	Immediata Cause (Finel disease or condition resulting in daath)	a Lung Can	cer					1	l Year
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=	24 7 E	3 Suicida 6 Could not be 4 Homicida detarmined	28a. Place of Injury building, atc. (	- At home, farm, s (Specify)	treet, factory, office		28f. Location (St. City or Town		or Aural	Route Number,
_	Hospital 24 hours of Funeral right filled	29e. Cartifier 1 Certifying Phy	ysician: To the best of r	ny knowledga dea	th occurred at the til	ma date and place	and due to the ca	use(s) and mai	nner as sta	ated.
	To the Hospital within 24 hours a To the Funeral I completely filled Medical Ce		niner: On the basis of an and mannar state	camination and/or li						
	Withir Comp	29b. Signatura and titla of certifiar	1	la .	29c. Licens	se number	2	9d. Dete signed	(Month, E	Jay, Year)
	12	X	Xox	_ M	DD	4451.	3	JULY	19	, 1999
	10	30. Nama and addrass of person who d	complated causa of daa	th (Item 23a) (Type	, Print)					
		Sang-Kyune Lee, M	.D., 15201	Shady Gr	ove Road,	# 202, R	ockville	, Mary1	and 2	20850
	State	31. Date filed (Month, Day, Year)	32. Registrar's		/					
	Registrar	JUL 2 0 1999	1 Julian	D.	South	/				

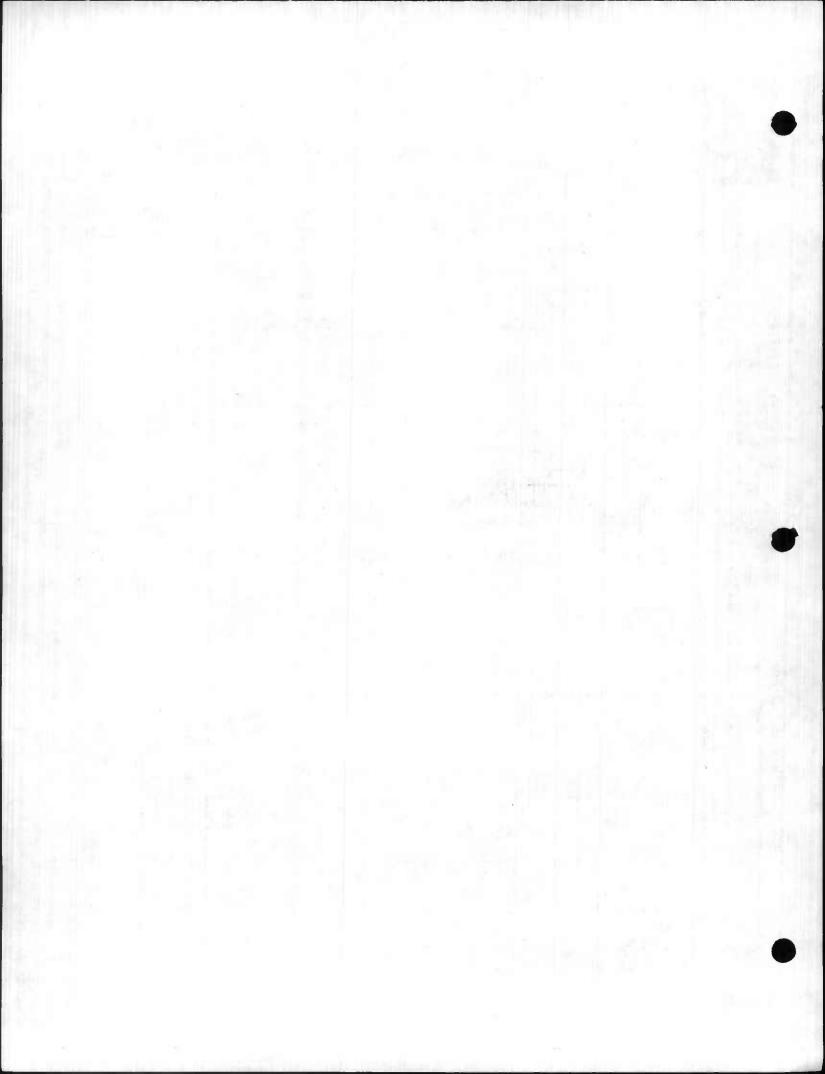


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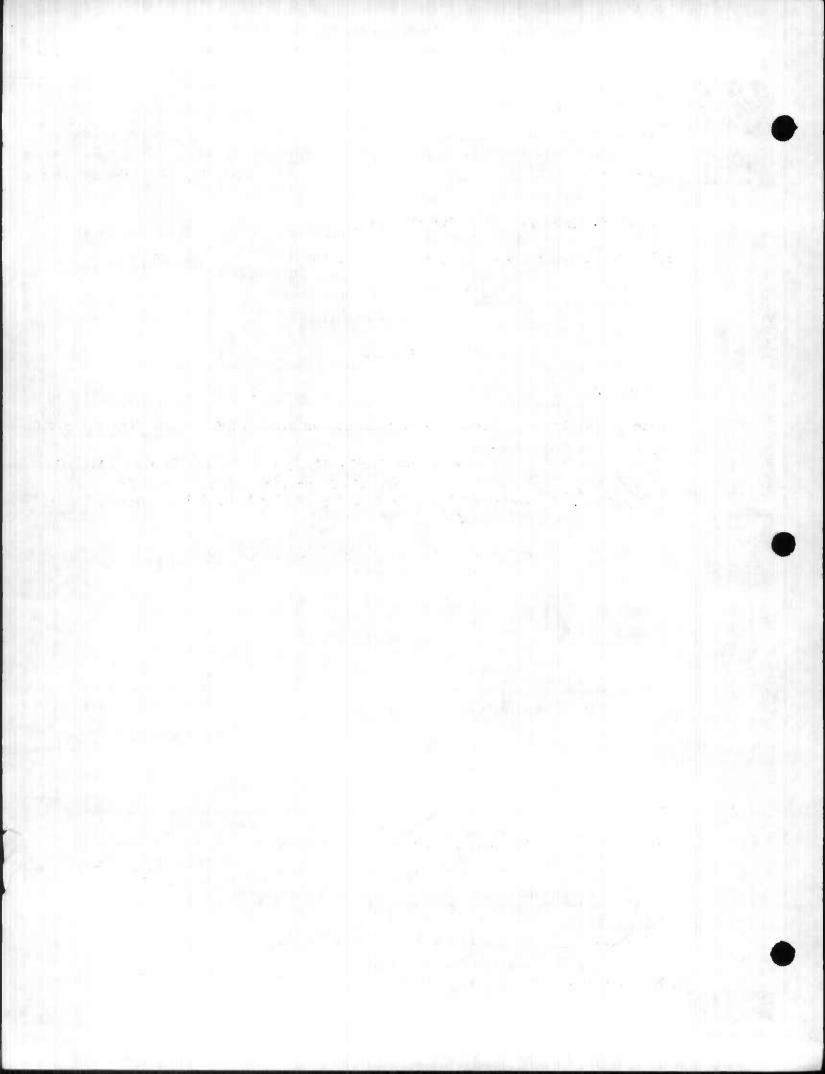
State of Maryland / Department of Health and Mental Hygiene 99

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						Cer	tificate of	Death			Reg. N	0.			
Physicia	_	1. Decedent's Neme (First, Middle,	ur.							2. Date of D Month	D	ay	Year	3. Time of Death	1
/Medica		Edith (	Gertrude				Kiss			July 1	8, 1	999	1001	10:10 AM	1
Examine		4a Facility Neme (If not institution, g 6108 Temple Stre		umber)				4b. City, To Beth		ocation of Dea	th 4	c. County Mont	of Death	rv	
Funeral		-	. Sex	7. Age	(In yrs. last bir	thday)	If Under 1 Year	If Under	24 Hrs.	8. Dete of B	rth .		0	lace (State or Fore try)	ign
Director		141-32-7929 Usuel Residence of Decedent	1□ M 2ÅF		76	Yrs.	Months Days	Hours	Min.	May 4,		"		gary	
/z nours energeam winn be Maryland naturel', or hama 23a or 28a-f ehow deal Examinat mart be notified at	-	10a. Stete 10b. County			10c. City, Tow	n or Loc	ation						1	0d. Inside City Lim	its
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	Completed	15. Decedent's (Specify only highest)	grade completed,			(Give I	kind of work done OO NOT use retire	pation during mos ad)	t of work	ting			ology		
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	o Be	Not Available			Toth			Maria						ailable	
	-	19a. Informent's Neme/Reletionship	(Type, Print)			. Mailin	g Address (Stree			rai Route Numi	er. City				
		Elemer Adam Kiss					Davos Ti								
		20a. Method of Disposition	, , ,		20b. Plece of	Dispos	ition (Name of		703.0	Dete			City or To	wn, Stata	
		1 ☐ Burial 2 ☑ Cremetion 3 4 ☐ Donetion 5 ☐ Other (Spe		Stete		-	etory or other ple	Jul	y 21	,1999					
4	-	21. Signeture of Funeral Service Lic	- A		Montgo		y Cremat							ryland meral Hom	0/
DUCE.		At Am J	101	M000	189	Ве	thesda-(	Chevy	Chas	se, Inc	. 7	557	Wisco	nsin Ave	.,
		23a Part I Amenilla disease, or co				not ente	r the mode of dy	ing, such as	cardiac	or respiretory	errest,	201		Approximete Interval Between	
an		Control of the Cist of	ly one cause on	eech iiin	9.								1	Onset end Death	
al		tmmediete Cause (Final disease or condition	M	eta	ctati	1	reast		. 0/				1	25 years	
er		resulting in death)	a		Due to (or es a			can	cer				1 4	23 9000	
	Je l						331130 317.						1		
	Examiner	Sequentially list conditions	b		Due to (or es a	consequ	uence of):								
		Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying					server.						i		
	Ca	Cause (Disease or Injury that initieted events	C	D	ue to (or es e o	onsequ	ience of):								
	Medical	resulting in death) Last	d										1		H
	Physician	Part II. Other algnificant conditions	contributing to d	leath but	t not resulting in	the un	deriving cause of	iven in Pert t		23b. Did	tobacc	o use cor	atribute to	the cause of dea	th?
	TY.						, y				Yea			pably 4 Unkn	
	by P											_ 14		,	
										24a. We	s en aut	opsy		ere eutopsy tinding	S
	Completed									pen	omed?		CO	mpletion of cause death?	
	Ĕ										Yes :	N No		Yes 2□ No	
		25. Was case reterred to medical	1					00 DI	-10			2421 140		JYes ZUNO	
- 6	o '	examiner?	Hospitet:		• • • • • • • • • • • • • • • • • • • •		or not or	her		h (Check only		a Dou			
1	-	27. Menner of Death	28a. Dete	Inpatien of Injury		rime of	3LI DOM	4U Nt	7	ome 5⊠ Res 28d. Describe				/)	
	10	1 Natural 5 Pending investiget	(Mor	nth, Day		njury		nyet ork? ]Yes 2 □							
	Ca	3 Suicide 6 Could not	be 29a Diag	e of Iniu	ry - At home, fe	rm stre	et, fectory, office			28f. Location	(Street s	and Numb	er or Rura	I Route Number.	
	Certification:	4 ☐ Homicide determine	build	ling, etc.	(Specify)	1111, 0110	et, lectory, critice			City or To			01 01 11012	7710010 710111001,	
		29a. Certifier 1X Certifying I	Musician. To the	hoot of	mus kan asala dan	doubh	annumed at the ti	inn data an	d place	and due to the		a) and		ated	_
	edicai		aminer: On the b and mer	asis of e	examinetion en	, death d/or inv	occurred at the ti estigation, in my	me, date an opinion, dee	th occur	red et the time	cause( , date e	nd place, a	and due to	the cause(s)	
		29b. Signature end title of certifier		,			29c. Licen	se number			29d. D	ate signed	d (Month,	Day, Year)	
		Moura	45	57	5	MO	D	43083			Ju1	y 19	, 199	9	
	-	30. Name and address of person wh	o completed con-	se of do	eth (Item 23a)	Type 5	Print)								
		George A. Sotos,					nter Dr	#30	0. 1	Rockwi 1	10	MD 2	0850		
State		31. Date filed (Month, Day, Year)			's Signeture	_ 08	TICEL DI	· , π 3 U	U, I	CCKVII	16,	ELD Z	0000		
Stati Registra	6	JUL 2 1 19		ener	_	9.	Loux	1							
		00L - 10		-			popo volo	100							



		Certificate	e of Death	Re	g. No.	
	Physician	1. Decedant's Nema (First, Middla, Last)  +OHN  KIVLAN		2. Dete of Death	-	3. Time of Death
	/Medica Examine	4e Facility Neme (If not institution, give street and number) MONTGOMERY GENERAL HOSPITM	4b. City, Town, or L	ocation of Deeth	4c. County of Death	
	Funeral Director	5. Sociel Security Number  5. Sociel Security Number  5. Sociel Security Number  1 M 2 F  89  1 Months  Wonths	1 Yaar If Under 24 Hrs. Deys Hours Min.	8. Data of Birth (Month, Dey, June 19,		place (Stata or Foreign intry) sachusetts
	vith the Maryland or 28a-1 show	10e. State 10b. County 10c. City, Town or Location  Maryland Montgomery Silver Spring  10e. Street and Number 10f. Zip	Code	10	g. Citizen of Whet Cou	10d. fnside City Limits 1 ☐ Yes 2 ☑ No
020	urs after death v	1 □ Navar Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give 1 □ Yes 3 ☑ Widowed 4 □ Divorced Year or Detes:	20906 dent of Hispenic Origin? (S sify Cuban, Mexican, Puert 2反 No Specify:	pecify Yas or No- o Rican, etc.)	USA 14. Race - Amar Bleck, White	
21215-0020	C ' .	15. Decedent's Education (Specify only highest grede completed)  Elementery/Secondary (0-12)  Collega (1-4or 5+)	rk done during most of wor		6b. Kind of Business/li	
and 21	should be file and Mental Hy amarked oth ummatic event	17. Fetners Neme (First, Middle, Last)		ne (First, Middle, M	Law feiden Sumeme)	
Maryland			Anna J (Street and Number or Ru	rel Route Number,		
	bermit. Pagas 1 and 2  Department of Health important: If Item 27 is any Injury or other tree page.	23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mod shock, or heert feilure. List only one ceuse on each line.  fmmadiata Ceuse (Finel disease or condition resulting in deeth)	Home, Inc.	ng,Maryland		
Box 68760,	cartificata be assouted nding physician and usa as the bunal-transit	Due to (or es e consequence of):  Sequentielly list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest  Due to (or es e consequence of):  Due to (or es e consequence of):				
.o.	that the death ca	Pert II. Other significant conditions contributing to death but not resulting in the underlying of	eause given in Pert I.			to the cause of death?
S, D	w requires that the base signed by should be dated	INTERTRACHANTERIC FRACTURE OT HIP		1 Ye	n autopsy 24b. V	Obably 4 Unknown  Were autopsy findings avelleble prior to
of Vital Record	8 8 8			1 ☐ Ye		completion of cause of deeth?
ivision	Physician: this cartificant	Suicide   Suic	DA Other: 4 Nursing H	28d. Describe ho 28f. Location (Str. City or Town S IWMS s, end due to the ce pared et the time, de	nce 6 Other (Special National Parts   Special	steled. to the couse(s)
	State	30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)  CALL MARCOLLI, M.O. (5MK) 11125 ROCK  31. Date filled (Month, Dey, Yeer)  32. Registrar's Signature	vius like	, lockvi	ue, mo	10852

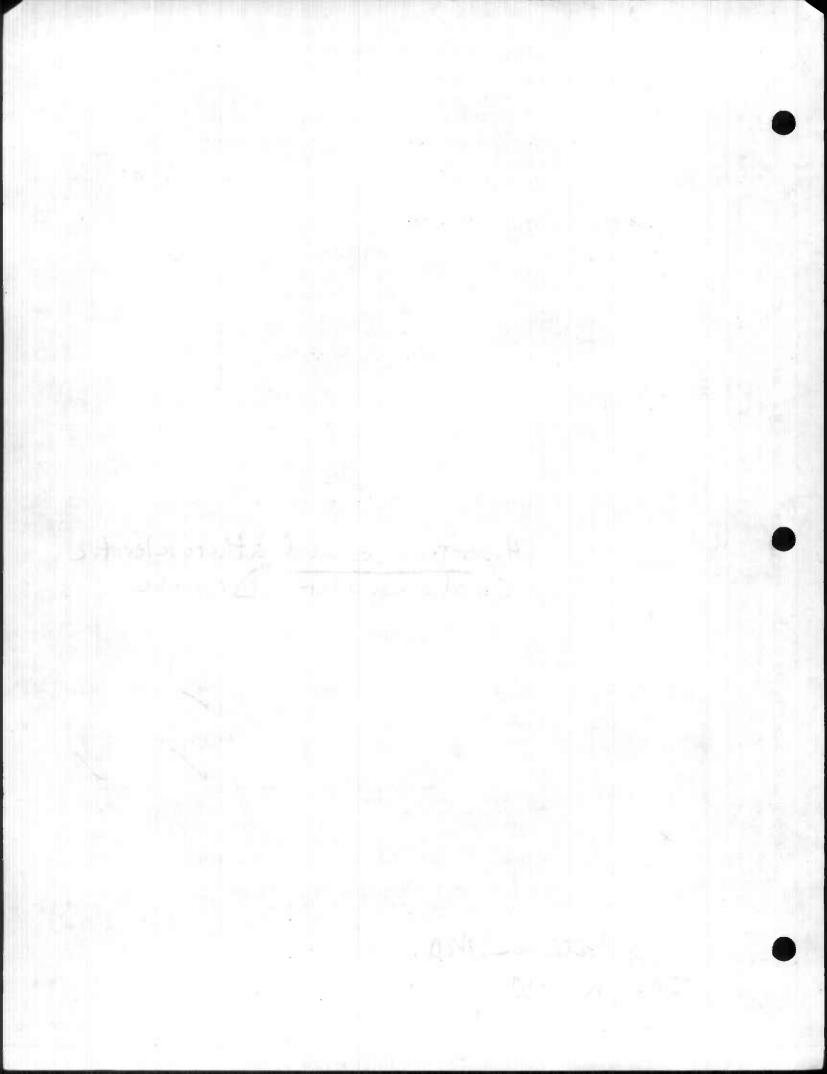


## Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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tac	dinov					Ce	rtifica	ate of	Death		Reg. N	lo.		_ 1011	
			1. Decedent's Name (First, Middle, L.	est)						2. Date of	Death		4	3. Time of Death	
	Physicia	_	Helen Kostadinov	7						July	1			01:06 AM.	
	/Medica Examine		4a Facility Name (If not institution, gi		oer)				4b. City, Town,	or Location of De				102100 1211	
			Calver	t Memoria	al Hos	nital			Prince	Frederi	ok	Cals	ort		
	Funeral		5. Social Security Number 6.	Sex 7.		. last birthday)		er 1 Yea	If Under 24 h	irs. B. Date of				laca (State or Foreign	
	Director		220-76-7016	1 ☐ M 2 💢 F	6	Yrs.	Month	s Days	Hours M						
Н	D		Usual Residence of Decedent			V		1		Uaiiuai	y	1,17.17.	Hai	yranu	
	how		10a. State 10b. County		10c. C	ity, Town or Lo	ocation						1	Od. Inside City Limits	
	M P	cto	Maryland Prince G	eorge	Gre	enbelt								1 ☐ Yes 2 XNo	
	# 72 B	Director	10e. Street and Number				10f. 2	ip Code			10g. C	itizen of Wh	at Cour	ilry?	
	th will	8	10L Plateau				20	770			Unit	ed St	Year 1999 01:06 AM ounty of Death  Calvert  9. Birthplaca (State or Fore) County)  10d. Inside City Limi 1 Yes 2 Xh on of What Country?  I States Raca - American Indian, Black, White, etc.  pecity: White I of Business/Industry  Manufacture umame)  Town, State, Zip Code)  Land 20657 Intion - City or Town, State Wood, Maryland  Maryland 20722  Approximate Intervel Between Onset and Death  Levol (C		
	ours efter death with the Maryler st', or frems 23s or 28s-f show Esserting: mart be notified at	Funeral	11, Marital Status	12. Was Decede		J,S. 13.	Was Dec	edent of	Hispanic Origin?	(Specify Yes or lerto Rican, etc.)	No-				
0	of a se		1 Never Married 2 Married	1 Tes 2			_	2 No		,			····nto,	oto.	
90	ours in all.	g p	3 ☐ Widowed 4 反 Divorced	Year or Date	9 <b>s</b> :			- 27	oposity.				hite	2	
21215-0020	within 72 hours efter death with the Maryland ene. then "natural", or flems 28e or 28e-4 show the Madical Essenting must be inclined at	ete	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Dece (Give	kind of 1	vork done	during most of t	working	16b.	Kind of Busi	ness/Inc	dustry	
2	yiene.	du	Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	DO NOT	use retin	9d)						
	CA TO THE O	Ö	12			Accoun	ntan	t Su	pervisor						
ī	d out	Be	17. Father's Name (First, Middle, Las	")					18. Mother's N	Name (First, Midd	fle, Maide	en Sumame)			
Maryland	d 2 should be filed with th and Mental Hygiene. 7 is marked other ther traumatic event, train	2	Harry Litts						Floren	ce Lanha	ım				
la la			19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Numbe									umber, City or Town, State, Zip Code)			
			Michael J. Nanc	e Jr. / S	on	12649 Place of Dispo	Hig	nsie	rra Driv		Mai	yland	206	557	
Ore	2 2 2 2		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Date	20c.	Location - Ci	ity or To	wn, State							
E	permit. Pages Department of I Important: If its eny injury or of phos.		4 Donation 5 Other (Speci			t Lince	oln	Crema	atory	7/22/99	Brei	twood	. Ma	arvland	
ait	Semit. Pa Separtmen mportant: any injury		21. Signature of Funeral Service Lice	nsee		2:	2. Name	and Addr	ess of Facility					<del></del>	
<b>B</b>	Ped Ped Ped Ped Ped Ped Ped Ped Ped Ped		Janua S	1 mille	00				ln Funer		1 = 1 = 1	d Ma	~ s v 1 /	and 20722	
			23a. Part1. Enter the disease, or con shock, or heert teilure. List only	plications that cau	sed the dea	th. Do not en	ter the m	ode of dy	ing, such as care	diac or respiratory	arrest,	ou, na	Lyla	Approximete	
4	Physician		SHOCK, OF HEET LENGTH. LIST OFFI	One cause on eec	arme.				٨			l.		Onset and Death	
7	/Medical		Immediate Cause (Final disease or condition	Hu	pert	PMS	INP	(	and	athe	200	scle	rot	-ic	
п	Examiner		resulting in death)	a. ///	Puo to (	00000000	1 // -	0		1				10	
Н	D #	ner		0	a cod	MAGA	SC	c. 1	a -	1/15	ea	SC			
	death certificata be executed e attending physician and od for use as the burial-transit	Examiner	Sequentially list conditions,	b	Due to (	or as a consec	quence o	f):		m , ,	, —				
o,	ana lana		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										i		
68760,	nysic he b	edicai	that initiated events resulting in death) Last	C	Due to (	or as a consec	quence o	):						SE SESTI	
	ing pt	8	resulting in deathy East										1		
Box	attendir			d											
	death	Physician	Part II. Other significant conditions	contributing to deat	h but not res	sulting in the u	nderlying	cause g	iven in Part I.	23b. D	ld tobacc	co use contr	ribute to	the cause of death?	
P.0	d by the	2								1	Yes	2□ No 3	□ Prol	bebly 4 Unknow	
Ś	5 60	2	•							_					
of Vital Record	v requires been sign should be	8								24a. W	as an au				
S	as been 2 shoul	Completed			_					-			CO	mpletiop of cause	
æ	The law ate has page 2	E								1.5	Yes	2 No	1.6	Dies 2 No	
ta	cartifical rector, p	0	25. Was case referred to medical						26 Place of I	Death (Check on					
>	P	0	examiner? 1 XYes 2 No	Hospital:	ationt 2X	ER/Outpatie	nt 3 🗆	0	ther		1	6 ∏Other	/Snacif	6/1	
	r this	-	27. Manner of Death	28a. Date of	Injury	28b. Time o		28c. Inje		28d. Describ	-		-	//	
O	ding th. Aftar funa	0	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		Day Year)	Injury	М		ork? ]Yes 2□No						
Division	Attending ar death. ector: Afta by the fune	Certification:	3 Suicide 6 Could not to	OB Class of	Injury - At h	ome, farm, str	reet, fact	ory, office		28f. Location	(Street	and Number	or Rura	al Route Number,	
5	or Att		4 Homicide		etc. (Speci						Town, Sta				
	Hospital 24 hours Funerel staly filled		29a. Certifier 1☐ Certifying Pt	veician: To the be	est of my kno	wierine deat	h occurre	d at the t	ime date and old	ace and due to the	DA CRIJEA	(s) and man	107 95 S	tated	
	How Fun	edical			s of examina										
	2522	29b. Signature and title of certifier 29c. License number								29d. [	Date signed (	Month,	Day, Year)		
	H 3 H ö		Date of the		nn	Y									
	20	-	* Telle	we	110	IJ,		(	D.C.M.E.			JUly	18,	1999	
			30. Name and address of person who	opmpleted cause	of death (Ite										
			31. Date filed (Month Day, Year)	32 Ban	istrar's Sign		stre	et, I	Baltimor	e, Mary	and	21201			
	State Registra	_	A 4 10	19	access of the	4	1	20. "	,						



				Certificate	or Death	1	Reg. No.				
nysician	1. Decedent's Name (First, Mid					2. Date of Dec	6, Day 999	Veer	e of Death		
Medical .		OLAI	KRAEMER	•				11:	40PM		
xaminer	4a Facility Name (If not instituti	ion, give street and nu	mber)		4b. City, Town, or	Location of Death	4c. County	of Death			
	ST. MARY'S				LEONARI			MARY'S			
neral	5. Social Security Number	6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs. last bi	Months [	rear If Under 24 Hr. Days Hours Mir	. (Month, Da	h y, Year)	9. Birthplaca (Sta Country)			
ctor	556-42-5745	· <b>A</b> 201	85	Yrs.		MARCH	20,1914	RUSSIA	1		
	Usual Residence of Decedent 10a. State 10b. Count	lv .	10c. City. Tow	n or Location				10d. Insid	e City Limits		
rector			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		E OVER				res 2 □ No		
Director	MD. ST.	MARY'S		LEONARD			10g. Citizen of V	26	W 15		
à				10f. Zip Co							
rai		DAR LA,		140.111.70	20650		U.S.A.				
Funerai	11. Marital Status	Armed Fo	edent Ever in U,S. proes?	If Yes, specify	t of Hispanic Origin? ( Cuban, Mexican, Pue	rto Rican, etc.)	Blac	e - American Indiar k, White, etc.	1,		
by F	1 Never Married 2 Mar 3 Widowed 4 Divorce	If Yes Gi	/0	1 ☐ Yes 2 🖁	No Specify:		Specify	WHITE			
		ent's Education		Decedent's Heuri	logunation						
lete	(Specify only high	est grade completed)	108	Give kind of work of the DO NOT use if	done duning most of we retired)	orking	16b. Kind of Business/Industry				
Completed	Elementary/Secondery (0-12)	College (	College (1-4or 5+) BRICKMASON			1	MASONRY				
5	17. Fether's Name (First, Middle	a, Last)		DIGON		me (First, Middle,					
o Be	WILHEL	M FREDERI	CK KRAEN	מימו <i>ו</i>	<u> </u>	משטווו מישעי	TATE	TT ACMOST			
ř	19a. Informant's Name/Relation				itreet and Number or F	KERTTHER		State Zin Code)			
		MER/WIFE	136			10	n, ony or roun,	01010, 24 0000)			
	20a. Method of Disposition	Pusity WIFE	20b. Plece of	of Disposition (Neme	of	Date	20c. Location -	City or Town, State	9		
	1 Burial 2 Cremation		State cemete	ory, crematory or othe	r placa)						
	4 Donation 5 Other (		CHAI	MBERS CREM		7/18/99	RIVERD	ALE, MD.			
	21. Signature of Funeral Service	e Ligerane	0	22. Name and A	Address of Facility						
	W/11. W	ambus	M0009:	CHAMBERS	FUNERAL H	IOMES,P.A	. RIVE	RDALE , MD.	20737		
	23a. Part1. Enter the diseese, a shock, or heart failure. List	or complications that o	aused the death. Do	not enter the mode of	f dylng, such as cardia	ac or respiratory a	rrest,	Approxi	mate Between		
ın		,							nd Death		
il er	Immediate Cause (Final disease or condition		Canc	er of h	iver:			m	WIL.		
al and	resulting in deeth)	Ð	Due to (or as a	en of h consequence of):		-			orcing.		
ine			Carci	mma (	of on.						
Examiner	Sequentially list conditions,			consequence of):	0-0-1			1			
Ē	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury	<b>J</b>									
edical	that initieted events resulting in death) Last		Due to (or as a	consequence of):							
		L.									
an		d									
Physician/M	Part II. Other significant condit	tions contributing to d	eath but not resulting	in the underlying cau	se given in Part I.	23b. Dld	tobacco uae cor	ntribute to the cau	se of death?		
Phy						10	Yes 2 No	3 Probably	4 Unknown		
by						-					
Pa							an autopsy	24b. Were eutor available pi	sy findings		
plet						pono		completion of death?	of cause		
Completed						10	res 20 No	1 ☐ Yes	2 No		
	25. Was case referred to medic	al la			26 Plane of Dr	eath (Check only o		10.00			
		14	Inpatient 2□ER/O	utpatient 3 DOA	Othor:			or (Capally)			
o Be	examiner?			-							
To Be	examiner? 1 Yes 2 No										
2	examiner? 1 Yes 2 No  27. Manner of Death 1 Netural 5 Pend	ling 28a. Dete (Mon	of Injury th, Dey Year) 28b.	Injury M	Work? 1 ☐ Yes 2 ☐ No						
2	examiner?  1 Yes 2 No  27. Manner of Death  1 Netural 5 Pend inves 2 Accident inves 3 Suicide 6 Could	ling (Mon		М	1 ☐ Yes 2 ☐ No	28f. Location (	Street and Numb	er or Rural Route	Vumber,		
2	examiner?  1 Yes 2 No  27. Manner of Death  1 Netural 5 Pend 2 Accident inves 3 Suicide 6 Could	28a. Dete (Mon	of Injury th, Dey Year)  of Injury - At home, fing, etc. (Specify)	М	1 Yes 2 No	28f. Location (3 City or Tox		er or Rural Route i	Vumber,		
Certification: To	examiner?  1 Yes 2 No  27. Manner of Death  1 Netural 5 Pend inves  3 Suicide 6 Couldeter  4 Homicide	d not be mined 28e. Place build	of Injury - At home, fing, etc. (Specify)	M arm, street, factory, o	1 ☐ Yes 2 ☐ No	City or To	vn, Stele)		Number,		
Certification: To	examiner?  1 Yes 2 No  27. Manner of Death  1 Netural 5 Pend inves 3 Suicide 6 Could deter  29a. Certifier (Check only 2 Medica	ing 28a. Dete (Mon stigation of not be mined 28e. Place build ing Physician: To the in Examiner: On the build in the stigation of the build in the stigation of	of Injury - At home, fing, etc. (Specify)  best of my knowledgests of examination ar	M arm, street, factory, o	1 Yes 2 No	City or To	vn, Stete) cause(s) end me	onner as stated.			
edical Certification: To	examiner?  1 Yes 2 No  27. Manner of Death 1 Netural 5 Pend inves 2 Accident 3 Suicide 6 Could deter  29a. Certifier (Check only one)  27. No 27. No 28. Certifier 29 Medica	ing doubt a state of the line	of Injury - At home, fing, etc. (Specify)	M arm, street, factory, o	1 Yes 2 No ffice  the time, date end plac my opinion, death occ	City or To	vn, Stete) cause(s) end me dete and pleca, o	onner as stated. and due to the cau	se(s)		
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JUL 20 1999

NAME: NICOLAI KRAEMER

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth **Physician** Month Veer NORMAN KRUHM 21, July 1999 12:45 PM /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner Wilson Health Care Center at Asbury Village Gaithersburg Montgomery 7. Age (In yrs. lest birthday)

Q 1 Yrs.

| If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year)
| Oct. 21, 19 Birthpiece (State or Foreign Country) **Funeral** 1₽M 2□F 220-28-5253 1907 Director Maryland Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours aftar death with the Maryland nent of Health and Mental Hygiene. Intil 1 Items 21 are 23a or 28a-f show intil 1 Items 27 is marked other than "naturel", or items 23a or 28a-f show any or other traumatic event, makedical Examinar matter notified at any or other traumatic event, makedical Examinar matter notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo Maryland Montgomery Gaithersburg 10e. Street end Number 10f. Zlp Code 10g. Citizen of Whet Country? #909 415 Russell Avenue, 20877 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indien, Black, White, etc. 1 ☐ Never Married 2 Merried 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ♥ No Specify: Specify. þ 3 Widowed 4 Divorced white Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Farmer Farming 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) Be Frederick William Kruhm Mary Lillian Duva11 P 19e. Informent's Name/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 415 Russell Avenue, #909 Gaithersburg, MD Beatrice D. Kruhm, 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, State permit. Pages
Department of
Important: If It
any Injury or o 1 Burial 2 □ Cremetion 3 □ Removel from Stete July 24 4 ☐ Donetion 5 ☐ Other (Specify) 1999 Union Cemetery Burtonsville, MD of Funeral Service License 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr., gaithersburg, MD 20877 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximeta Intervei Between Onset and Deeth **Physician** /Medical Immediete Ceuse (Finel Electrolyte Imbalance diseese or condition resulting in deeth) Examiner Examiner Domontic A12 helmer's 160m physician and the burial-transit The law requires that the death certificate be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or es e consequence of) signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown Coronary Artery Oisease ð 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? Cardiac Oysithymia, Gasto-Esophageag certificata has linector, page 2 a Reflux 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice 25. Wes cese referred to medicel examiner? Be 28. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No funeral 28a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 1 PNeturel 5 Pending 1 ☐ Yes 2 ☐ No Investigetion 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Streef and Number or Rural Roufe Number, City or Town, Stete) 4 Homicide To the Hospital of within 24 hours at To the Funeral D completely filled it 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edical 29e. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) Principa (telletar Lyon mo July 22, 1999 10 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)
Priscilla Cullahan-Lyon, mo 911 Russell Ave Gaithers burg mp 80879 Callahan - Lyon, mo h, Dey, Year) 32. Aggistrer's Signeture

State Registrar 31. Dete filed (Month, Dey, Year)

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Philosophy which has an appearable against the philosophy with the

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month 55 KATHERINE MAE KOPPLEMAN 6 07 4e. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth DORCHESTER GENERAL HOSPITAL CAMBRIDGE DORCHESTER If Under 1 Year Months Deys If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthdey) 5. Sociel Security Number 8. Dete of Birth (Month, Day, Year, Birthplece (State or Foreign Country) 1□ M 21XF Months 215-36-1845 Yrs 62 FEB. 20. 1937 MARYLAND Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MARYLAND DORCHESTER HURLOCK 10e. Street and Number 10g. Citizen of Whal Country? 10f. Zip Code 4907 HARRISON FERRY ROAD 21643 USA 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Meritei Status 14. Rece - American Indien, Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) HEATING FUEL SECRETARY 11 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) WILBERT HANNIBAL HOFFMAN EMMA LOUISE DISKAU 19a. Informent's Neme/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) JEROME C. KOPPLEMAN, JR./HUSBAND 4907 HARRISON FERRY ROAD, HURLOCK, MD 21643 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State EAST NEW MARKET CEMETERY 7/21/99 EAST NEW MARKET, MD 4 Donetion 5 Other (Specify)
21. Signature of Fineral Service Leany ZELLER FUNERAL HOME, P. O. BOX 207, 106 MAIN STREET, EAST NEW MARKET, MD 21631 Fart J. Enter the disease, or complications the baused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart leiture. List only one such a each line. Approximete Intervel Between Onset end Death Immediate Cause (Finel disease or condition resulting in death) Due to (or es e consequence of) 1 Week lumonia Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence ol) Due to (or es e consequença of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Carcinoma t ☐ Yee 2 No 3 Probably 4 ☐ Unknown 24b. Were eutopsy lindings avellable prior to completion of cause of death? 24e. Wes an autopsy performed? 1 Yes 1 ☐ Yes 2 No 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 27. Manner of Deeth 28b. Time of 28d. Describe how Injury occurred 28e. Dete of Injury (Month, Dev Year) 28c. Injury at Work? 1 Neturet 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, lerm, street, fectory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, Stete) 4 - Homicide

lew requires that the death certificate be axecuted physician and s the burial-transit Division of Vital Records, P.O. Box 68760, attending pl signed by the a d be datached f certificate hes t director, page 2 s Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica director, funeral á 24 hours after Funeral Dire lietely filled in b To the Hospi within 24 hou To the Funer completely fil

**Physician** /Medical

Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours attar death with the A Department of Health and Mental Hygiene, important if Nem 27 is marked other than "natural".

Director

Funeral

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Examiner

Physician/Medical

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Certification:

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1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and menner stated. 29d. Date signed (Month, Day, Year)

JUL 2 0 1999

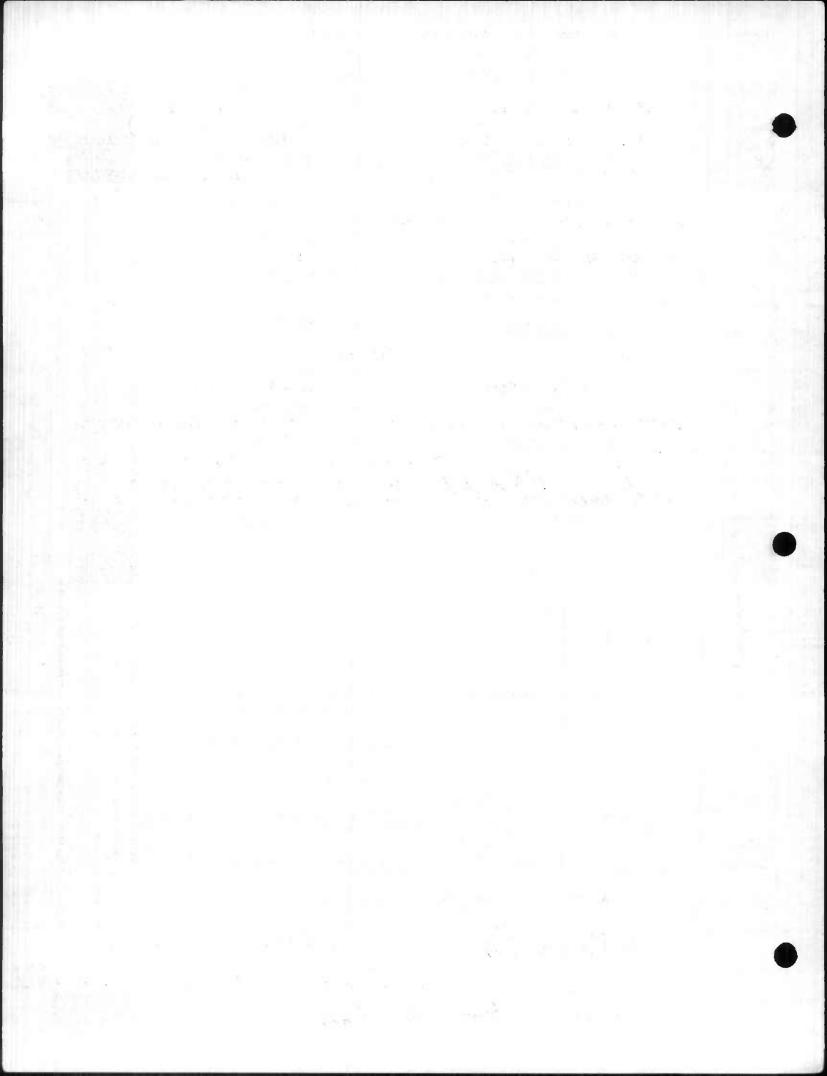
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrer's Signature

William 31. Dete liled (Month, Dey, Year)

Franklin St. Cambridge, MD 21613

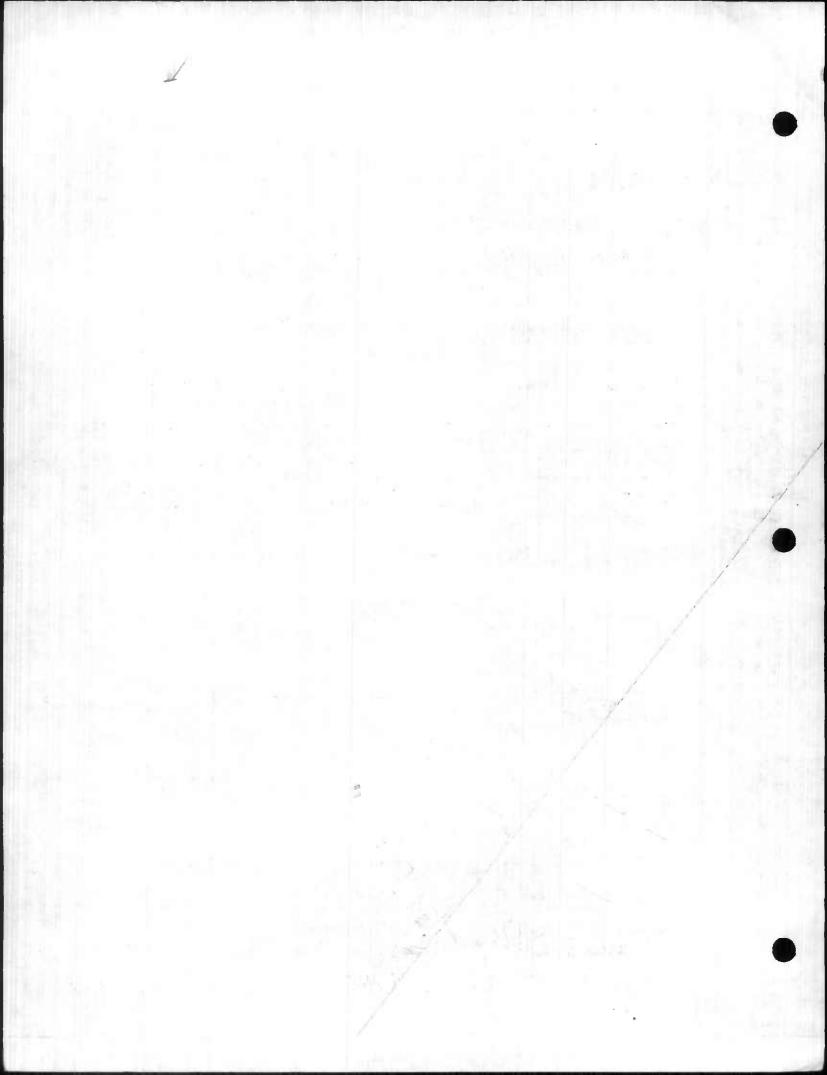
State Registrar



# Elizabeth Knotts

Please	Type or Print in Black Indelible Ink. Assure All Copies Are Legible	e.
	State of Maryland / Department of Health and Mental Hygiene	
	0-10-1-0-11	

	Certificate of Death	Re	g. No. 99	243/5		
Dhualaian	Decedent's Name (First, Middle, Last)	2. Dete of Death	Day Year	3. Time of Deat		
Physician /Medical	Elizabeth Emma Knotts	July	0.0	99 1845		
Examiner	4a Facility Name (If not institution, give street and number)  4b. City, Town, or	Location of Death	4c. County of De			
	The Memorial Hospital Easton		Talbo	t		
Funeral Director	5. Social Security Number 222-20-4320 6. Sex 1 Months 1 M	8. Dete of Birth (Month, Day, Dec 26,		rthplace (State or For Country) 1aware		
naturel', or tems 23e or 28a-f show deal Examiner must be nothed at sted by Funeral Director	Usuel Residence of Decedenf  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Lin		
15 0	Maryland Talbot Cordova			1 Yas 2		
be notified Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What C	Country?		
10 H	31016 Skipton Cordova Rd 21625	USA				
el', or items 23a or 28a-f ahow Examiner must be notified at by Funeral Director	11. Marital Status  12. Wes Decedent Ever in U,S. Armed Forces?  1 Never Merried 2 Married  1 Never Merried 2 Married  3 Widowed 4 Divorced  12. Wes Decedent Ever in U,S. Armed Forces?  1 Yes 2 No Specify:  1 Yes 2 No Specify:	pecify Yes or No- to Rican, etc.)	14. Rece - American Indien, Black, White, atc.  Specify:  White			
"natural".	15. Decedent's Education 16a. Decedent's Usual Occupation		6b. Kind of Businas			
	(Specify only highest grade completed)  (Give kind of work done during most of work for both life. DO NOT use retired)  (Give kind of work done during most of work for both life. DO NOT use retired)	rking				
omp	Elementery/Secondary (0-12) College (1-4or 5+)  8 Homemaker		own home	2		
d other vent.		me (First, Middle, N	faiden Sumame)			
o Be	Harry Lemuel Collins Edna 1	Florence	Davis			
eumetic evant, press	19a. Informent's Name/Relationship (Type, Print)  19b. Meiling Address (Street and Number or Ru			Zin Code)		
	Parallel					
important: if item 27 in any injury or other tr	20a. Method of Disposition  1 Disposition  1 Disposition  2 Disposition (Name of cametery, crematory or other place)  4 Donation 5 Other (Specify)  21. Signeture of June al Service Licensee  22. Name and Addrass of Fecility  Fleegle & Helfenber	Dete 2 uly 26,19 in Funera	99 Green  Home PA	sboro, Ma		
	May ( ley PO Box 160 Green	nsboro, M	aryland			
-	23a. Pert 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac shock, or haert failure. List only one cause on each lina.	c or respiratory erre	esf,	Approximata Intervel Betwee Onsat and Deal		
edical aminer	Immedieta Causa (Final disease or condition resulting in death)  a. Carrivomatosis ? lung  Dua to (or as a consequence of):	or co	lon	1 mo		
ng physician and as the burlat-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):					
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d for	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23h Did to	bacco use contribu	to to the cause of d		
igned by the attendir be detached for usa by Physician/A	Smoker			Probably 4 Doni		
2 should		24a. Was er perform		. Were autopsy findi available prior to completion of caus of death?		
page Com		1 ☐ Ye	s 2 DNo	1 ☐ Yes 2 ☐ No		
certificate rector, pa	25. Was case referred to medical 26. Place of Der	ath (Check only on	9)			
	examiner?  1 Yes 2 No Hospitel: 1 Dinpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing H	foma 5 ☐ Rasida	nce 8 Other (Sp	pecify)		
nerthi neral	27. Manner of Death  1 Interval 5 Pending (Month, Day Year)  28a. Dete of Injury (28b. Time of Injury Work?  2 Accident investigation  28a. Dete of Injury (Month, Day Year)  M 28c. Injury ef Work?  1   Yes 2   No	T	w injury occurred	3.11		
To the Functei Director: After to completely filled in by the funeral Medical Certification:	3 Suicide 6 Could not be detarmined 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)	City or Town	, State)	Rural Route Number,		
pletaly fill edicai	29a. Certifier  (Check only  (C	e, end dua to the ca arred et the time, da	use(s) and manner atta and place, and de	as stated. ua to the causa(s)		
Med	and menner steted.					
000	29b. Signature and title of certifier 29c. License number		9d. Date signed (Mo			
	Charles & D38996		7-24-			
	30. Name and addrass of person who completed causa of death (Item 23a) (Type, Print)	MAR	MD, Z			
	Charles E. Di Napoli M.D. EA	STON	MD. Z	1601		
State	31. Data filed (Month, Day, Year) 32. Registrer's Signeture					
Registrar	JIII 2 8 1999 Danier 4					



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State of Maryland / Department of Health and Mental Hygiene

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Amended Item#5 perFH G774 8/10/99 EW Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** July 19, 1999 5:45 PM Evelyn Tucker Lee /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) **Examiner** Cape St. Claire Anne Arundel 1142 Skyway Dr. Skyway Manor If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Sociel Security Number 213-12-9841 **Funeral** 1□M 2□F XX Yes Director 9/25/1907 Maryland <del>577-12-373</del>2 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits na 23a or 28a-f show must be notified at 1 Yes 2FINO Directo Maryland Anne Arundel Mayo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural', or flems 23a 21106 USA 1300 Mayo Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status hours after 1 Never Married 2 Merried 1 Yes No If Yes, Give altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White ğ 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) 8 Taxation State Government permit. Pages 1 and 2 should be fits.
Department of Health and Mental Hy, important: if hem 27 is metried other any Injury or other two 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Be Alice (Unknown) Weems Tucker 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) 1300 Mayo Rd. Mayo, MD 21106 Andrew Grubb (friend) 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Chemation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln 7/21/99 Brentwood, MD on of Funeral 22. Name and Address of Fecility John M. Taylor 147 Duke of Gloucester St. 21401 Wes 23a. Pert1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximete Interval Between Onset and Death **Physician** tmmediate Ceuse (Final disease or condition resulting in deeth) /Medical Fai Lure to Thrive 6 mous **Examiner** Due to (or es e consequence of) Examiner interm: ttent Amorexia Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Lest Due to (or es e consequence of): and SeniLity Box 68760. physician Physician/Medical Due to (or as e consequence of): P.O. Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1□ Yaa 2⊠No 3 Probably 4 Unknown bengis be det Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital Mospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifical eleby filled in by the funeral director; Be 25. Was case referred to medicet 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Group Hm 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Natural 5 Panding 1 ☐ Yes 2 ☐ No 2 Accident investigetion 8 Could not be determined 3 Sulcide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and magner stated. 29a. Certifier Medical (Check only one) within 2 To the I 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) XJary 211. W JONES MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W JONES MD PO BOX 385 Laurel Md 20725-0385 GATY

**DHMH 16 Rav 6/95** 

State

Registrar

31. Dete filed (Month, Day, Year)

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32. Pegistrer's Signature

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State of Maryland / Department of Health and Mental Hygiene Q Q 21. 277

		, , , , , , , , , , , , , , , , , , , ,	Certificate of			I. No. ,	4011	
Dhyeleiar	1. Decedent's Name (First, Middle, Last)				2. Dete of Death Month	Day Year	3. Time of Death	
Physician /Medica		Linea H. Lee			July 15		2:55PM	
Examine				4b. City, Town, or L	ocation of Death	4c. County of Death		
	Crofton Convalesce			Crofton H Under 24 Hrs.	10.04.45:4	Anne Arundel		
Funeral Director	5. Social Security Number 6. Sex 216-82-3270	7. Age (In yrs. 79	Yrs. Months Days		8. Date of Birth (Month, Day, 19 Oct.3,19	Year) 9. Birthp Court 919 Swed	iace (State or Foreign htry) en	
ahow a show	10a. State 10b. County		y, Town or Location	٩		1	0d. Inside City Limits 1. Yes 2 No	
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ti you	3728 Bay Dr.			037	10	g. Citizen of What Cour USA	itry r	
offer death v	2 11. Merital Status	2. Was Decedent Ever in U,			ecity Yes or No-	14. Race - Americ	an Indian,	
15-0020 72 hours after death with the Manyland "natural", or items 23s or 28s-f show indical Examiner must be notified at		Armed Forces?  1  Yes 2 X No If Yes, Give Year or Dates:	If Yes, specify Cub		Rican, atc.)	Black, Whita, Specify: Whi		
72 22	15. Decedent a Educ (Specify only highest grade	completed)	16a. Decedent's Usuel Occu (Give kind of work done life. DO NOT use retire	pation during most of work	sing 10	6b. Kind of Business/Inc	dustry	
d 21215- filed within 72 Hygiene. wher than "nat ont, the Mage	Elementery/Secondary (0-12)	College (1-4or 5+)	Homemaker			At Home		
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aryian should be and Mental marked o umafic eva	I Erick nagg			Edith	J. Oste	rberg		
Aar 2 sho and 1s m	19e. Informant's Neme/Relationship (Typ.		19b. Mailing Address (Stree	t and Number or Rur	ral Route Number,	City or Town, State, Zip	Code)	
O SEE	Eugene B. Lee, J.		Same as Item	10	D-4- T av	0.1	C.	
Baltimore, comit. Pages 1 an Department of Heal Important: If them and Injury or other page.	1 □ Burial 2 □ Cremetion 3 □ Re		emetery, crematory or other ple	oce)	Dete 26	Oc. Location - City or To	wn, State	
altim nit. Ps artmen ortant: Injury	4 Donation 6 Other (Specify)  21. Signature Funeral Service License	/ Lak	emont Memorial		7/17/99	Davidsonvil	le, Md.	
Baltimore permit. Pages 1 Department of I- Important: if he any Injury or ot	23a. Part I. Enter the disease, or complications, or heart failure. List only on				eral Home	e, P.A.	21037	
	23a. Part I. Enter the diseese, or complication, or heart failure. List only on	ations that caused the death cause on each line.	h. Do not enter the mode of dy	ing, such es cardiac	or respiretory arres	sewater, in	Approximate Intervel Between	
Physician /Medical Examiner	Immediete Cause (Final diseasa or condition resulting in death) a.	V	t vascular di			1	Onset and Deeth UNKNOWN	
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68760, icate be executed physician and stree burial-transit and edical Examiner	Secured by the conditions	- ny perte	r as e consequence of):					
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requires that the real resigned by the hould be deteched	<u> </u>				1 🗆 Yes	2 2 No 3 □ Prol	bably 4 Unknown	
Division of Vitai Records, P.O. Box ( or Attending Physician: The lew requires that the deeth certificater death.  Director: After this certificate has been signed by the attending tin by the funeral director, page 2 should be detached for use a entification: To Be Completed by Physician/Min	fracture of	hip			24a. Was an perform	ed? av.	ara autopsy findings ailable prior to mpletion of cause death?	
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f Vital Ryylclen: The lyylclen: The ly secondicate had director, page	25. Was pase referred to medical			26. Place of Deet	th (Check only one			
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ng Pt her th	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of linjury 28c. Inju	iry at ork?	28d. Describe how	v injury occurred		
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Division o  To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examination	cian: To the best of my known: or: On the basis of examinat and manner stated.	wledge, death occurred et the ti tion and/or investigation, in my	ime, date and place, opinion, deeth occur	end dua to the cau red at the time, dat	use(s) and menner as si e and place, and due to	tated. the cause(s)	
To th Vithir Comp	29b. Signature and title of certifier	110	29c. Licen		29	d. Data signed (Month,	Day, Year)	
	> Jekkult Dug	WU	12	8640	4	JU14 16	, 1999	
	30. Name and didress of person who de	pleted cause of death (from	1 23a) (Type, Print)  M (UI) 21114	TE	FFPEV	BRIGG	CMA	
State Registrar	31. Dete filed (Month, Day, Year)	32. Redistrar'a Signal	ture 4	4~1	- Car	~~/99	5,110	

DHMH 16 Ray 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Frank Lunacek, Sr. July 18, 1999 7:09 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 775 Quince Orchard Boulevard, #21 Gaithersburg Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1♥M 2□F 63 352-48-4127 Director Jan. 18, 1936 Czech Republic Usuet Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits show must be notified at 1 No Yes 2 No Maryland Montgomery Gaithersburg Directo 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? Nems 23s or 775 Quince Orchard Boulevard, #21 20878 United States Funeral 14. Race - American Indian, Black, Whita, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Evar in U,S. Armed Forces? filed within 72 hours after 1 Never Merried 2 Merried 1 ☐ Yes 2 🔯 No If Yas, Giva Baltimore, Maryland 21215-0020 natural, or 1 Yes 2 No Specify: ğ 3 Widowed 4 Divorced White Yeer or Detes: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elemantery/Secondery (0-12) College (1-4or 5+) 8 Laborer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Be Department of Health and Mental Important: If Nem 27 is marked of any Injury or other traumatic eve 2 Jan Lunacek Lucie Richter Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Ralationship (Type, Print) Frank Lunacek, Jr. (son) 20 East Scott Street, Chicago, Illinois 60610 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 X Cremetion 3 ☐ Removal from Stata 7-20-99 Beltsville, Maryland Chesapeake Crematory 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Name and Address of Fecility Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Death Physician /Medical tmmediate Cause (Finel diseasa or condition resulting in death) METASTATIC PROSTATIC CARCINOMA Examiner Due to (or es a consequence of): Examiner physician and s the burial-transit that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in deeth) Lest Dua to (or as a consequence of): Box 68760, Physician/Medical Due to (or es a consequence of): attending for use as 23b. Did tobacco use contribute to the cause of death? Pert II. Other algorificant conditions contributing to death but not resulting in the underlying causa given in Part I. O 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 0 been signed I should be det þ Records, 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy Completed The lew page 2 1 Yes 2 No 1 ☐ Yes 2 No Division of Vital or Attending Physician: director, Be 25. Wes case referred to medical 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? 27. Menner of Death 28d. Describe how injury occurred 28b. Time of After 1 Neturel 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fun. 1 Yes 2 No Invastigetion 2 Accidant 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1 Certifying Phys fam: To the being of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only ar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) 2 Medical Exam 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 19/99 D22807 30. Neme and addrass of person who completed cause of death (ttem 23a) (Type, Print)

Registrar DHMH 16 Ray 6/95

State

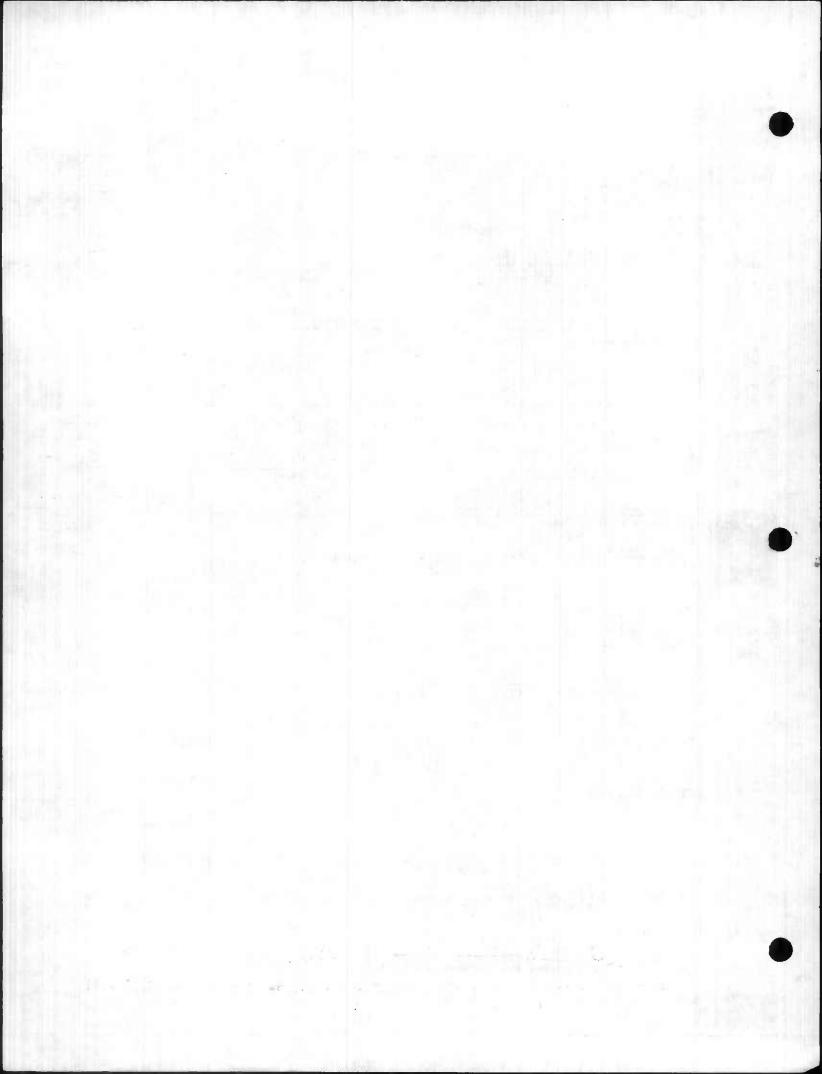
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Edward P. Gelmann, M.D., 3800 Resevoir Road, NW, Washington, DC 20007-2197

32. Registrar's Signeture

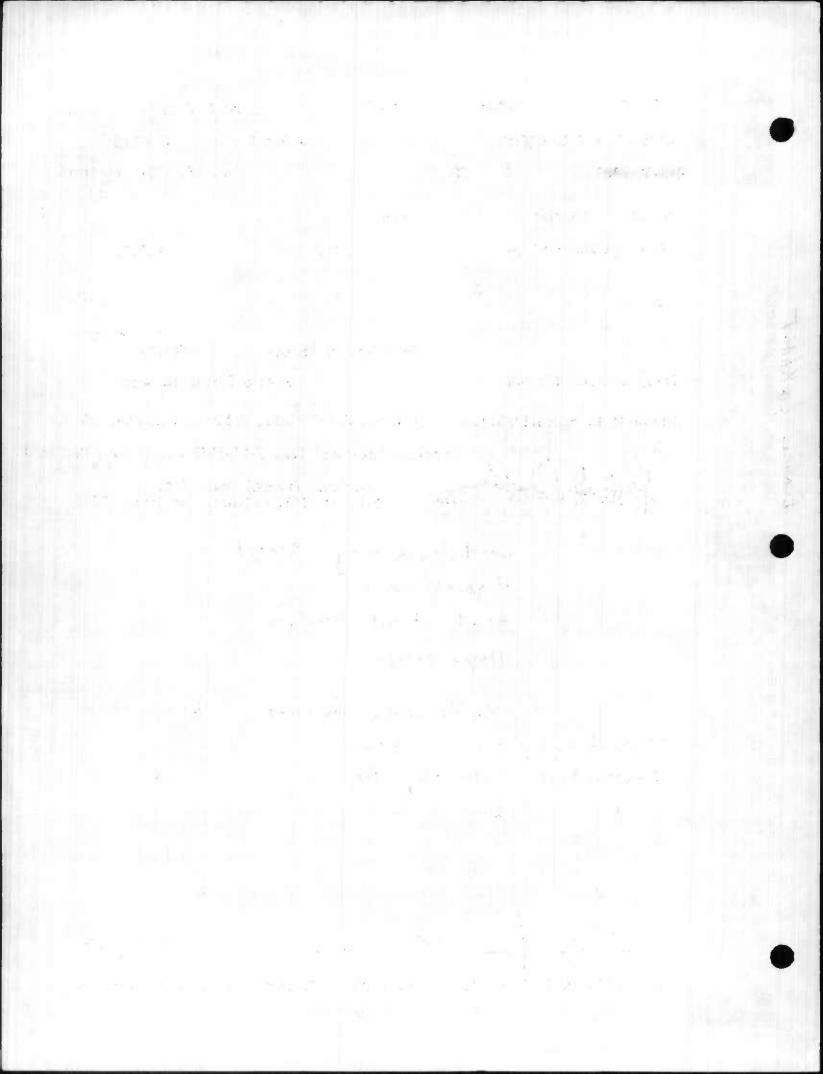
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State of Maryland / Department of Health and Mental Hygiene 99 24379

			Certi	ficate of	f Death		Reg. No.		
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Examiner	4e Facility Name (If not Institution, give	street and number)			4b. City, Town, or L	ocation of Death	4c. County	of Deeth	
	CIVISTA MEDICAL C	ENTER			LA PLATA		CHAR	LES	
Funeral Director	5. Social Security Number 6. Se 451-42-5703  Usual Residence of Decedent	7. Age (In yrs. )		If Under 1 Yea Months Days		8. Date of Birt (Month, De Jan. 1	7, 1931	Cou	plece (Stete or Foreigr ntry) ginia
Mand Mand	10a. State 10b. County	10c. City	y, Town or Locat	tion				1	10d. Inside City Limits
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eath with the Marylan se 23a or 28a+ show must be notified at eral Director	10e. Street end Number 44 Kings Wharf P	lace		10f. Zip Code 2060			10g. Citizen of V		ntry?
020 ura atter d art, or than Examiner.	11. Marital Status  1 Never Married 2 Married  3 🕅 Widowed 4 Divorced	12. Was Decedent Ever in U, Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Yeer or Detes:		s Decedent of es, specify Cu Yes 2 🕅 No	Hispanic Orlgin? (Sp ban, Mexican, Puerto o Specify:	ecify Yes or No- Rican, etc.)	14. Rec Blac Specify	k, White,	can indien, etc. White
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	17. Father's Name (First, Middle, Last)		F000 3	service	Worker 18. Mother's Nem	a /First Middle	County	o l	
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laryla 2 should and Man a marke numetic	19a. Informant's Name/Reletionship (T)	pe. Print)	19b. Mailing	Address (Stree	et end Number or Rus				o Code)
O TO DE	Henrietta L. Fauce				rf Place,				20602
other t	20a. Method of Disposition	0.0	liece of Dispositi emetery, cremet	/41 /	lece)	Date	20c. Location -	City or T	
Page Natification	1  Burial 2  Cremetion 3  F 4  Dogation 5  Other (Special	emoval from State Mar	yland V	eterans	s' Cem. 7-	27-1999	Chelter	nham,	, Maryland
Baltimore permit. Pages 1.s Department of He Important: if item any injury or othe	21. Signature di Funeral Sargice Licens	HAWN MOOD53	1	The Hun	ress of Fecility			00	CO.4
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Re law	Obstructure	Pulman	ar I	0740	14	101	res 2 No	1	☐Yes 2☐No
f Vital Respectant That is certificate he director, page	25. Was case referred to medical		vy	7.00	26. Plece of Deel	th (Check only o	ne)	1	
of V  Physical this ce al direct To E	exeminer?	lospital: 1 Inpatient 2	ER/Outpetient	3 DOA	Other: 4 Nursing Ho	ome 5 Resid	dence 6 □Oth	er (Speci	(fy)
Vision of Vita Attending Physician: ordeath. ector: After this certifica by the funeral director, fillication: To Be C	27. Menner of Death  1 Naturai 5 Pending investigation	28e. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Inj W M 1[	ury at ork? ☐ Yes 2 ☐ No	28d. Describe h	now injury occur	red	
Divisio	3 Suicide 6 Could not be determined	28e. Plece of Injury - At ho building, etc. (Specify	ome, ferm, street	, fectory, office	9	28f. Location (5 City or Tox		er or Rur	al Route Number,
Division  To the Hospital or Attance within 24 hours after death To the Funeral Director: completaly filled in by the	29a. Certifier 12 Certifying Physical Condition (Check only one) 12 Medicat Examt	lician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, deeth or tion and/or inves	ccurred et the tigation, in my	time, dete end plece, opinion, deeth occur	end due to the red at the time,	cause(s) end me date and place,	enner es s and due t	steted. to the cause(s)
within To the comp	29b. Signature and title of certifier			29c. Lice	nse number		29d. Dete signe	d (Month,	Day, Year)
	1 3 2	1-	9	D-33	3426		7/2	0/9	79
•	30. Name and eddress of person who co	mpleted cause of deeth (Item	23e) (Type, Pri						-
	B. LARRY JENKINS	M.D. 111 LA	AGRANGE	AVENUE	P.O.BOX 1	724 T.A	PLATA M	D_20	646
State Registrar	31. Dete filed (Month, Dey, Year)  JUL 2 3 19	32. Registrar's Signat	ture /	Som	Ka			_ =	



-033Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () McMillan AMEND ITEMS: #23 PART I, 27 PER MEO G774 8-4-99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day Year **Physician** ALLEAN MCMILLAN 1999 July 10 05:55 AM. /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Center Prince George's Cheverly If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth
(Month, Day, Year)
April 10,1950 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Washington, D.C t□M 2XF Months Hours Yrs 578 70 9485 49 Director Usual Residence of Decedent t Oa. State t 0b. County t Oc. City, Town or Location t 0d. Inside City Limits t Yes 2 □ No 28e-f Directo Maryland Prince George's Riverdale 10e. Street and Number t Of, Zip Code t 0g. Citizen of What Country? 5 8 6325 Patterson Street 238 20737 United States Funeral . Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-iff Yes, specify Cuban, Mexican, Puerto Rican, etc.) t 4. Race - American Indian, Black White etc. filed within 72 hours after 1 Never Married 2 Married b 21215-0020 1 Yes 2 No Specify: Specify: Black ğ 3 Widowed 4 Divorced Year or Dates: Completed t6a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) t 5. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (t-4or 5+) Housewife Home Baltimore, Maryland t 7. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental H lant: If them 27 is marked oth lary or other traumetic even Be James Perry Ludie Calloway t 9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Donnell (Daughter) 900 Jessup Blair Dr.#2, Silver Spring, MD. 20910 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State t Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or 4 ☐ Donation, 5 ☐ Other (Specify) Ft. Lincoln Cemetery 7/20/99 Brentwood, Maryland 22 Name and Address of Facility
McGuire Funeral Service Inc. aral Service Lice 7400 Georgia Ave., N.W., Washington, D.C. 231 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Examiner Due to (or as a consequence of) Examiner The law requires that the deeth certificate be executed burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last and Due to (or as a consequence of) Box 68760, physiciar Physician/Medical the Due to (or as a consequence of) signed by the attending p P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown of Vital Records. þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 should certificate has 1 Yes 2□ No tXYes 2 No or Attending Physician: uneral director. 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: t ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) t Ves 2 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation Division 1 DNatural after death.

Director: Aff t ☐ Yes 2 ☐ No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital of within 24 hours at To the Funeral D edical 29a. Certifier t Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MP O.C.M.E. July 12, 1999 30. Name and address of person who completed cause of death (Item 23d) (Type, Print)

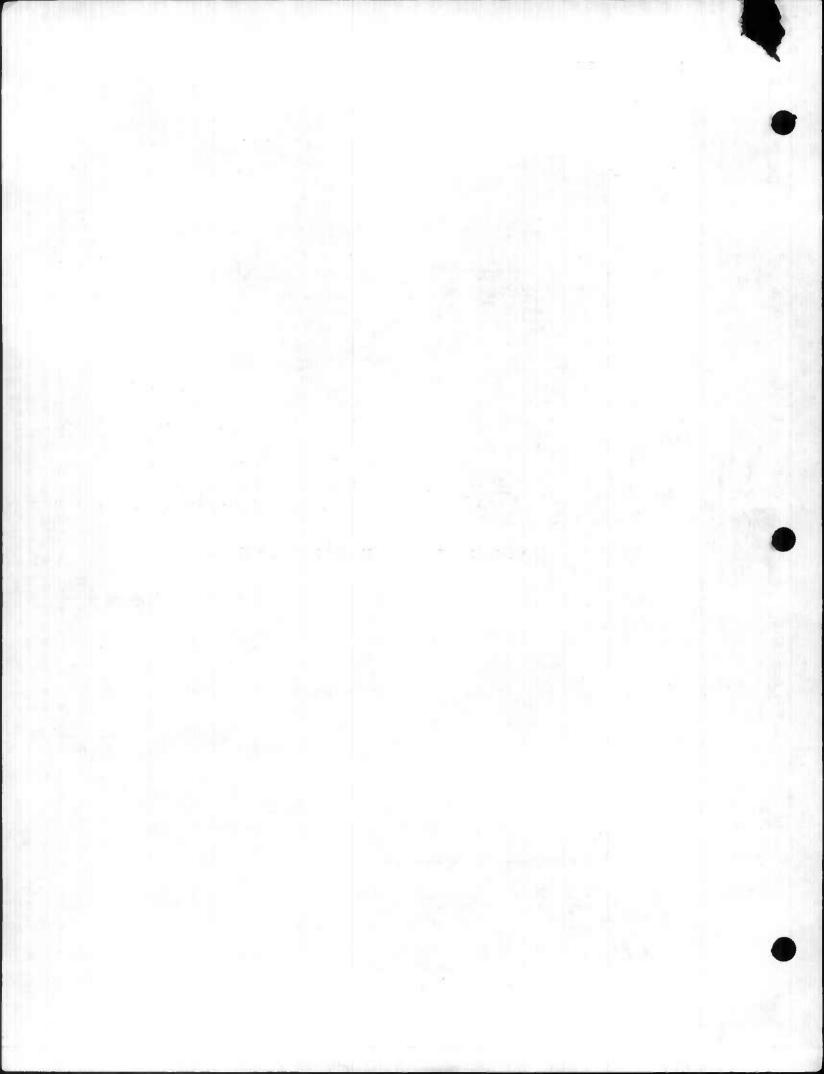
DHMH 16 Rev 6/95

State Registrar Stephen >
31. Date filed (Month, Day, Year)

19 1999

32. Registrar's Signature

Radiniz 111 Penn Street, Baltimore, Maryland 21201



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Examiner		ty Nama (If not institution		and number	)			4	b. City, Tov	vn, or Lo	cation of Deetl	h 4c. County	y of Death		
	_	405 Duxford					If Un -r	٠	Poton		6 D : 4D:		tgome		
uneral irector	277-	Security Number 94-3693 sidance of Decedant	6. Sex 1 M 2		ge (In yrs. la	Yrs.	Months		Hours	Min.	8. Data of Bir (Month, Da Aug. 2:	19, Year) 2, 1962	9. Birthp Court		a or Foraign
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23a or 2 at ban al Dir		et end Number 416 Parkval	e Rd.	#2			10f. Zlp (					U.S.A	whet Cont	itry r	
ral', or thems 23a or 28a-f show Exemple: must be notified at by Funeral Director		al Status Iavar Married 2□ Mai Vidowad 4ሺ Divorced	rried 1 [	as Decedent med Forces Yas 2 2 Yas, Giva aer or Dates:	?		Vas Deceda f Yes, speci I □ Yas 2		spanic Orig n, Mexican, Specify:	in? (Spe Puarto I	ocify Yas or No Rican, etc.)	14. Rai Ble Specif	ce - Amaric ick, White,		
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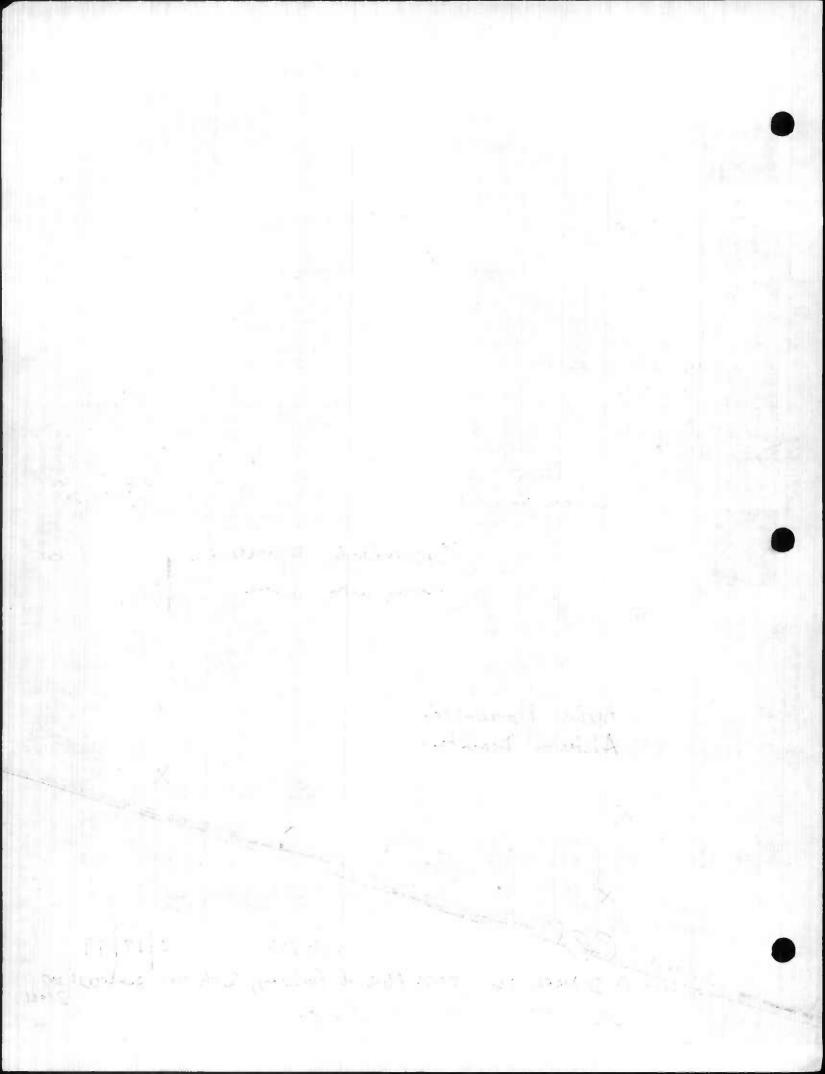
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State of Maryland / Department of Health and Mental Hygiene 9 9 24382

			Ce	rtificate of	Death	F	Reg. No.	L 700 L
	1. Decedent's Nama (First, Middle, Las	st)				2. Date of Dea	ath	3. Time of Death
Physician	L. Edward Mason					July	18 199	99 19:20
/Medical Examiner	4a Facility Name (If not institution, give				4b. City, Town,	or Location of Death	-	
ZAGITITICI	Anne Arundel Me	dical Center			Annapol	ie	Anne 7	Arundel
Funeral	5. Social Security Number 6. S		s. last birthday)		If Under 24	Hrs. 8 Date of Birth		
Director	579-01-3930 19 Usuel Residence of Decedent	XM 2□F 8	Car Control Hilliam	Months Days	Hours N	Min. (Month, Day Aug. 24		Birthplace (State or Foreign Country) alifornia
D E	10a. Stete 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
with the Maryland e or 28a-f show Libe notified at Director	MD Anne Arr	endel	Anna	polis				1 ☐ Yes 2 🛣 No
or 28a-f s. be notified	10e. Street and Number			10f. Zip Code	04.400		10g. Citizen of Wha	
death rms 23 rmsst	136 East Lake I				21403			JSA
020 urs after aff. or he Examine by Fu	11. Maritel Status  1 Never Merried 2 Married  3 Widowed 4 Divorced	12. Wes Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates:		Wes Decedent of If Yes, specify Cul 1 ☐ Yes 2 ☐ No		? (Specify Yes or No- uerto Rican, etc.)	Black, Specify:	American Indian, White, etc.  White
5-0 72 ho Micel Micel	15. Decedent's Ed			dent's Usual Occu		working	16b. Kind of Busin	ness/Industry
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7 = 14 -	Margaret Mason /	wife			e Dr. A	Annapolis,	MD 2140	)3
American Company of the Company of t	20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐		. Place of Dispo cemetery, cres	osition (Name of metory or other pla	ace)	Date	20c. Location - Cit	ty or Town, Stete
E de la la	4 Donation 5 Other (Specify		arklawn	Mem. Ga:	rdens	7-23-99	Rockville	e, MD.
Baltimo permit. Page Department of important: If any injury or once.	21. Signature of Funerel Service Licen	000						eral Home, Inc.
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Dhysisian	23a. Part1. Enter the diseese, or companies shock, or heart feilure. List only	olicetions thet caused the de one cause on aech line.	ath. Do not ent	ter the mode of dy	ing, such es car	diac or respiretory an	rest,	Approximate Intervel Between Onset and Death
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OX 68760, certificate be executed nding physician and use as the burial-transit n/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Ceuse (Disease or injury	Due to	(or as e consec	quence or):				1
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6876( fficate be g physicia as the bur ledical	resulting In death) Last	Due to	(or as a conseq	quence of):				
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. 0 00 -	Pert II. Other significant conditions or			inderlying cause g	iven in Pert I.	23b. Did t	obacco use contri	ibute to the cause of death?
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Reco							\.	of death?
The Interior						10 Y	res 2000	1 ☐ Yes 2 ☐ No
Of Vital I Physician: The Physician: The This cardificate ral director, page: To Be Co	25. Was case referred to medical examiner?				26. Place of	Deeth (Check only o	ne)	
Physic this ce ral dire	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2	ER/Outpatier	nt 3 DOA	ther: 4 Nursir	ng Home 5 🗆 Resid	lence 6 Other	(Specify)
O L G Ph g Ph neral neral neral	27. Manner of Death 1 ⊠Netural 5 □ Pending	28e. Date of Injury (Month, Day Year)	28b. Time o	28c. Inju	ury at	28d. Describe h	now injury occurred	
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Division c belor Attending Pi s after death. el Director: After ti led in by the funera Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe	home, ferm, str cify)	reet, fectory, office	)::	28f. Location (S City or Tow		or Rural Route Number,
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Divis  To the Hospital or Attention 24 hours after de To the Funeral Directo completely filled in by it	29a. Certifier  (Check only one)  Certifying Physics  Medical Example 1	ysician: To the best of my k iner: On the basis of exami and menner steted.	nowledge, deat nation and/or in	h occurred at the t vestigation, in my	ime, date and p opinion, deeth o	lace, and due to the o occurred at the time, o	ause(s) and mann date end plece, and	er as stated. d due to the cause(s)
Within on the one	29b. Signatura and title of certifier			29c. Licer	ise number		29d. Date signed (I	Month, Day, Year)
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	20. Name and address of person who of LISA A DINAM	completed cause of death (It		ledical	Parhva	7, 5, 74	100 An	infraul m
State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature 4	la	1.1			2(90)



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death JU14 17 Margaret Baugh McFarland 4a Facility Name (Il not institution, give street and Number) 8:05 PM 4b. City, Town, or Location of Death 4c. County of Death Hebrew Home of Greater Washington Rockville | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number | Gala Security Number MONTGOMERY 8. Date of Birth (Month, Day Year) May 21,1922 5. Social Security Number 9. Birthplace (State or Foreign Country) Virginia 77 579-20-4108 Yrs. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. inside City Limits ₩ Yas 2 No Montgomery Rockville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 90 Monroe Street, #504 20850 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒No 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 1 Never Married 2 Married Specify: White 1 Yes 2 No Specify: 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Sears Dept. Store 2 yrs Secretary 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Byron Baugh Emma ? 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Code) 5 2 19a. Informant's Name/Relationship (Type, Print) 11801 Rockville Pike, Penny Kirby (Daughter) #1101, Rockville, 20b. Place of Disposition (Name of cematary, crematory or other placa) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 XCramation 3 ☐ Removal from State Metropolitan F/Serv 7/19/99 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SNOWDEN FUNERAL HOME, 21. Signature of Funeral Service Licensee 20850 ROCKVILLE, MD Enter the disease, or complications that ceused the death. Do not entar the mode of dying, such as cerdiac or respiratory arrest, or hear failure. List only see cause on each line. Approximate tnterval Between Onset and Death . Small Cell Carcinoma of the Lung Immediate Cause (Final disease or condition resulting in death) Sequantially list conditions, if any, leading to immediate ceuse. Enter Underlying Causa (Disaase or Injury Dua to (or as a consequence of) Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 ☐ Unknown 24b. Ware autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy 1 Yes 2 No

**Physician** /Medical Examiner

certificete be executed

P.O. Box 68760

Division of Vital

i or Attending Physician: after deeth. Director: After this certifice

24 hours a Hospital

To the Within 2 To the

**Physician** 

/Medical

Examiner

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**Funeral** 

Director

Items 23a or 28a-f show ner must be notified at

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permit. Peges 1 and 2 should be filed within 72 hours effer c Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examinations.

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

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Completed Be funeral Certification:

that initiated avents resulting in death) Last

Part II. Other elonificant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was cese referred to medical examiner?

26. Place of Death (Check only one) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work?

28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred

Location (Street and Number or Rural Route Number, City or Town, State)

1 👺 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and dua to tha causa(s) and mannar as stated. 2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier 4. Mason M.D. 29c. Licanse number D22235

1 Yes 2 No

29d. Date signed (Month, Day, Year)

30. Nama and address of person who complated causa of daath (Itam 23a) (Type, Print)

Wesley B. Mason, M.D., 10810 Connecticut Ave, Kensington, MO., 20895 31. Date filed (Month, Day, Year)

Registrar

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JUL 20

5 Pending

investigation

6 Could not be datarminad

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifiar (Check only one)

> 32. Registrar's Signature Seneva

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Dav Month 1999 21, July | 5:49pm Mary\_K. Macfarlane 4b. City. Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Shady Grove Adventist Nursing & Rehab. Rockville mr | HUnder 24 Hrs. Montgomery If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 10M 20F Yrs. 164-09-3068 Sept 26, 1914 Pennsylvania 84 Usual Rasidance of Dacedant 10c. City, Town or Location 10a. Stata 10b. County 10d. Inside City Limits 1 Yes 2 No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20850 8 Baltimore Road USA Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, Whita, etc. 1 Yes 2 No If Yes, Give Year or Datas: 1 Nevar Married 2 Married 1 Yes 2 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Nama (First, Middle, Last) Gustav F. Rees Mary Ploppert 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John F. Macfarlane/ Son 917 Montrose Road, Rockville, MD 20852 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata July 24 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Gate of Heaven Cemetery 1999 Silver Spring, MD 21. Signature of Funaral Sarvice Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that cache the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each rie. MD 20901 Approximata Interval Between Onset and Death Immediata Causa (Final disaasa or condition rasulting In death) a Pneumonia Due to (or as a consequence of): b. Osteoarthritis Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disaasa or Injury that Initiated evants rasulting in death) Last Due to (or as a consequence of): c. Dementia Dua to (or as a consequence of): d\_Osteoporosis Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

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Box 68760.

Division of Vital Records, P.O.

**Physician** 

/Medical

Examiner

**Funeral** 

**Director** 

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Department of Health and Mental Hy
Important: If them 27 is marked offer
any Injury or other

Director

Funeral

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Completed

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hours after

Baltimore, Maryland 21215-0020

Examiner Physician/Medical by Completed

		1 Yes 2 No 3 Probably 4 Unknow
		24a. Was an autopsy performed?  24b. Were autopsy findings available prior to completion of cause of death?
		1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No
25. Was casa rafarred to medical	26. Place of Death	(Check only one)
axaminar? 1 ☐ Yas 2 ☐ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 42 Nursing Hon	ne 5 Residence 6 Other (Specify)
27. Mannar of Death 1 CNatural 5 Pending 2 Accident invastigation	(Month, Day Year) Injury Work?	Rd. Describe how injury occurred
3 Suicide 6 Could not be detarmined	28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify)	281. Location (Street and Number or Rural Route Number, City or Town, State)

To the Hospital o within 24 hours at To the Funeral Di

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier (Check only one) 29b. Signatura and titla of certifier

D4327

29c. License number 29d. Data signed (Month, Day, Year)

July 22, 1999

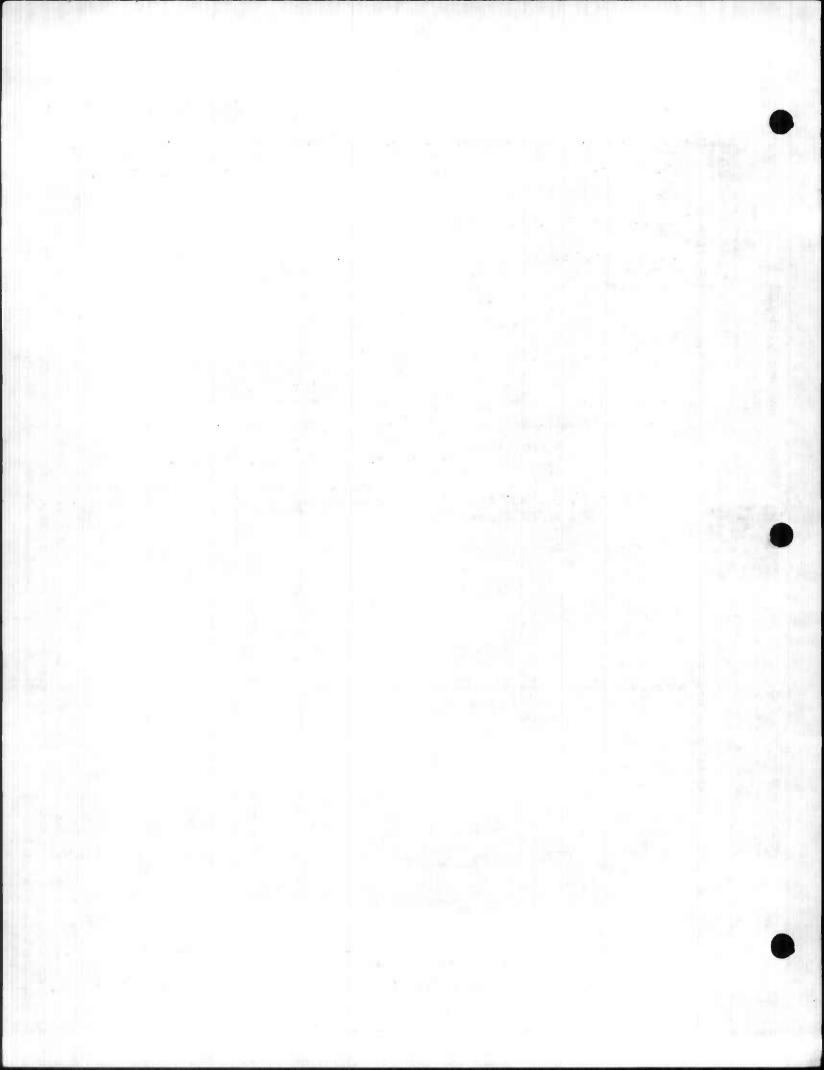
30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

809 Veirs Mill Road #101, Rockville, MD 20851 301-762-5019 Sunita Hanjura

State Registrar

31. Data filed (Month, Day, Year) 23 JUL

32. Registrer's Signature eneva



### Please Type or Print In Black Indeible ink. Assure Ail Copies Are Legibie.

State of Maryland / Department of Health and Mental Hygiene 🔾 🔾 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Tima of Death Month Charles Edward Mochwart July 17, 1999 11:50 PM /Medical 4a Facility Nama (Il not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Chevy Chase Montgomery Manor Care Chevy Chase If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
New York 6. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Days Months Hours 1 M 2□ F Yrs. 577-46-0535 64 1934 Aug. 8, Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Chevy Chase Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pin 4620 North Park Avenue, #1410E 20815 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) Race - American Indian, Black, Whita, etc. 1 ☐ Yas 2 ☑ No If Yas, Giva Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☒ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) Insurance Salesman 4 17. Father's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) 89 Myrtle Smith Russell Calvin Mochwart 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 7401 Westlake Terrace, #104, Bethesda, MD 20817 Deborah Worthington Mochwart (daughter) 20b. Place of Disposition (Name of cematary, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Data 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 7-19-99 Beltsville, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) Chesapeake Crematory 21. Signatura of Funaral Service Licensee 22. Name and Address of Facility Rapp Funeral Services, P.A. cusol 933 Gist Avenue, Silver Spring, Maryland 20910 Approximata Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Synovial Sarcoma 3 years Examiner Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immadiata cause. Entar Underlying Cause (Disaasa or Injury that initiated avents rasulting in death) Last Due to (or as a consequence of): Physician/Medical Dua to (or as a consequence of): Part II. Other alignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 Probably 4 Unknown þ 24b. Wera autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? 1 ☐ Yas 2 No 1 Yes 2 No Be 25. Was casa referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Mannar of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending invastigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 HomicIda 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifiar 29c. License number July 19, 1999 D0013771 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) David Luthringer, M.D., 5530 Wisconsin Avenue, #1240, Chevy Chase, MD

State Registrar

20

**DHMH 16 Rev 6/95** 

**Physician** 

**Funeral** 

Director

Nerns 23a or 23a-f show Der mast be notified at

natural, or

72 hours after

filed within Hygiene.

Pages 1 and 2 should be nent of Health and Mental ent: If fleen 27 is marked of

permit. Pages 1 and 2.1 Department of Health ar Important: If Item 27 is any Injury or other trau

physician and the burial-transit

2

signed b

page 2 s

certificate

this

After

death.

To the Hospital or Attendit within 24 hours after death.
To the Funeral Director: All completely filled in by the fu

40

that the death certificate be assouted

P.O. Box 68760.

Records.

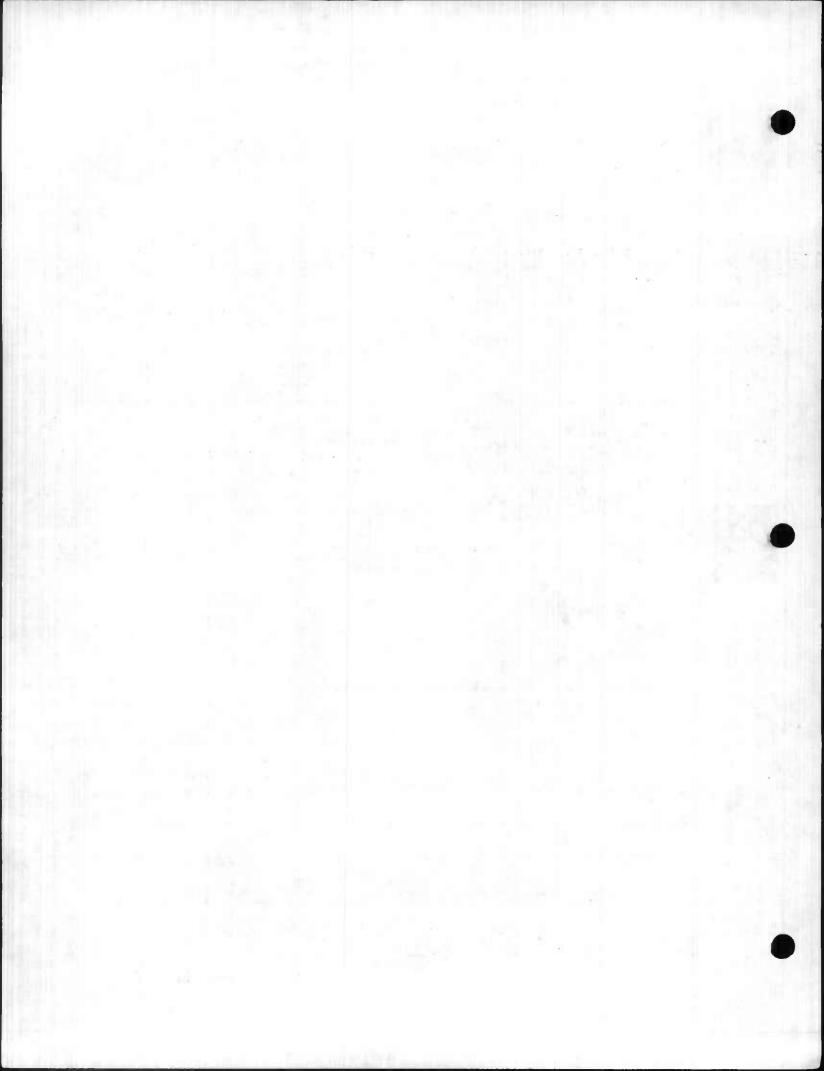
Division of Vital Attending Physician:

Baltimore, Maryland 21215-0020

31. Data filed (Month, Day, Year)

32. Registrar's Signatura

**ORIGINAL** 



#### Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene ()

24386 Certificate of Death 3. Time of Death 2. Dete of Deeth Month

12:13 A.M.

10d. Inside City Limits 1 ☐ Yes 2√ No

Approximate Interval Between Onset and Deeth

6 MONTHS

3 YEARS

1 ☐ Yes 2X No

White

Physician /Medical Examiner	
Funeral	

1. Decedent's Neme (First, Middle, Last)

permit. Peges 1 and 2 should be filed within 72 hours efter death with the Meryland Depertment of Heelth and Mentel Hygiene. Important: If itam 27 Ia marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event, the Medical Expriner must be not if a page.

Baltimore, Maryland 21215-0020

**Physician** /Medical Examiner

physicien and the buriel-transit law requires that the death certificate be executed Box 68760. 98 980 for ed by the e o signed b Division of Vital Records. certificate hes b or Attending Physician: director this funeral death. ector: by the Direc 24 hours effer Funeral Dire letely filled in b To the Hosp within 24 hor To the Fune completely fi

Ellen Molnar JULY 17 1999 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street end number) 4c. County of Death PRINCE GEORGE'S MALCOLM GROW MEDICAL CENTER CAMP SPRINGS If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1 M 2 XF 79 Yrs. 181-18-2928 1920 Pennsylvania June 25, Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location Directo VA Fairfax Alexandria 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 1048 Dalebrook Drive 22308 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2XXMarried 1 ☐ Yes 2 No Specify: Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Laborer Manufacturing 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) John Zorek Sophie Deptuch 19e. Informent's Neme/Reletionship (Type, Print) (Husband) 19b. Mailing Address (Street and Number or Burel Boute Number, City or Town, State, Zip Code) 1048 Dalebrook Drive Alexandria, VA Col. Alexander A. Molnar 22308 20b. Plece of Disposition (Name of cametery, cremetory or other placa) 20a. Method of Disposition 20c. Location - City or Town, Stete tXO\Buriel 2 □ Cremetion 3 □ Removel from State 7/21/99 4 □ Donetion 5 □ Other (Specify) Hillcrest Memorial Park Hermitage, PA 21. Signature of Funerei Servica Licansee 22. Name end Address of Fecility Metropolitan Funeral Service, Inc. aren 5517 Vine Street Alexandria, VA 22310 234 Paul Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, and or heart feiture. List only one cause on each line. Immediete Cause (Finel diseese or condition resulting In deeth) METASTATIC MALIGNANCY WITH ASCITES Due to (or es e consequence of) Examiner **COLON CANCER STAGE 4** Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury Due to (or es e consequence of): Physician/Medical thet initieted events resulting in death) Lest Due to (or es e consequença of) 23b. Did tobacco use contributa to the cause of deeth? Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown ATRIAL FIBRILLATION by 24b. Were eutopsy findings evalleble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? H/O DVT; ANTICOAGULANT ON HEPARIN 1 Yes 2 No ANEMIA 25. Wes case referred to medical exeminer? Be 28. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 TYes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 1 Neturel 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete and pleca, and due to the cause(s) end menner steted. (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifier AMM NYS 140658-1 JULY 17 1999 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 89 MDG/1050 W PERIMETER ROAD LEON W. KUNDROTAS, COL, USAF, MC ANDREWS AIR FORCE BASE MD 20762

32. Registrer's Signeture

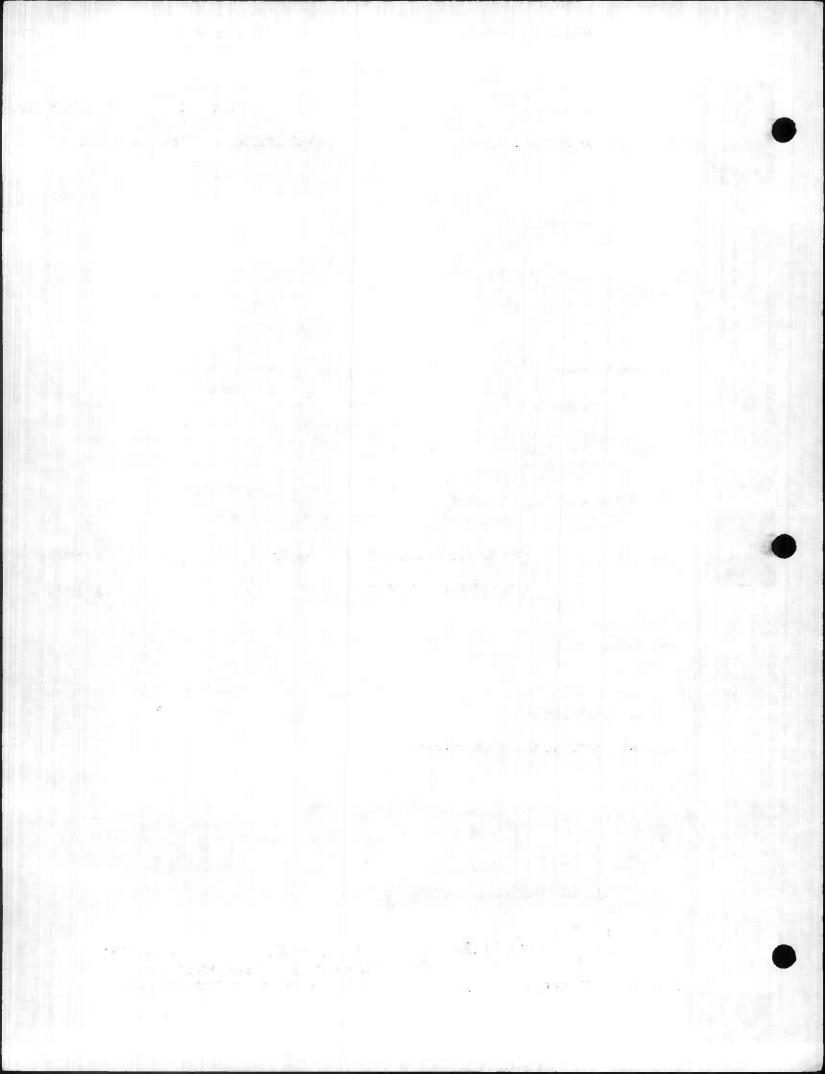
Registrar **DHMH 16 Rev 6/95** 

31. Dete filed (Month, Dey, Year)

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### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

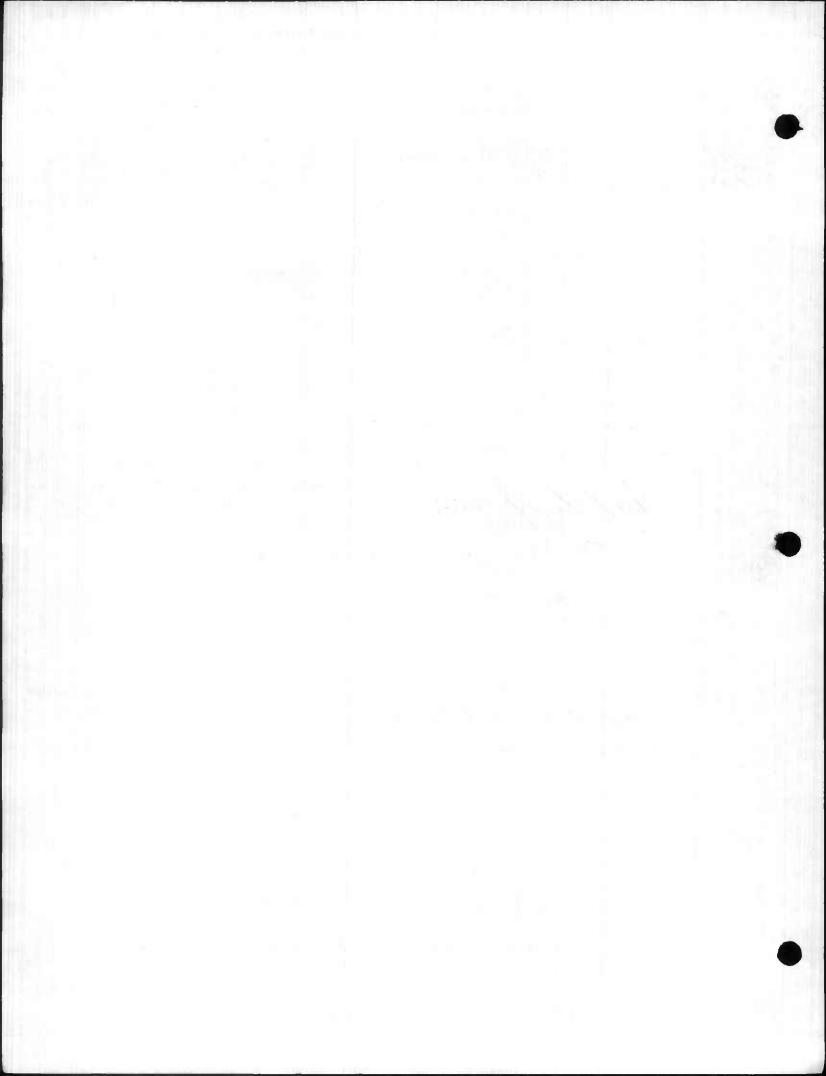
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** Day 999 Viola Gertrude Massey 13, July 4:50 p.m. /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Centreville Queen Annes Corsica Hills Nursing Home 7. Aga (In yrs. last birthdey) If Undar 1 Yaar If Undar 24 Hrs. Months Days Hours Min. 5. Social Security Number 8. Data of Birth (Month, Day, Year) Birthplaca (Steta or Foreign Country) **Funeral** 1 □ M 2 🖾 F Days 219-07-6562 Director Yrs. 93 May 30, 1906 | Pondtown, Marylan Usual Residence of Decedant 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f shor traumatic event, the Medical Examiner must be notified at Director Chestertown 1 TYas XXNo Maryland Queen Annes the 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? U.S.A. 220 Pine Tree Road 21620 Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Give Yaar or Datas: 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, White, atc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after tent of Heelth and Mental Hygiene. nt: If item 27 is marked other than "natural", or ite 1 Navar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: by Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) College (1-4or 5+) Pickling Plant Food Processor 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumema) Be Anne Gertrude Tiller Joseph Massey 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 1814 Pondtown Road, Chestertown, Maryland 21620 Gloria Cooper/Niece 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ₺ Burial 2 □ Cramation 3 □ Removal from Stata permit. Page Department of Important: If any injury or once. Mt. Pleasant Cemetery/July 17, 1999 Pondtown, Maryland 4 Donation 5 Othar (Specify) 21. Signature of Faneral Service Lice Fellows, Helfenbein & Newnam Funeral Home, P.A. PO Box 270, Millington, Maryland 21651-0270 that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, so on each line. **Physician** /Medical Immediata Cause (Final TR DIO Pulmonany disaasa or condition rasuiting in death) Examiner Examiner oncinona Sequantietly list conditions, if any, laading to immadiata causa. Entar Undarfying Cause (Disaasa or injury that initieted avants rasulting in death) Last Dua to (or as a consequence of) P.O. Box 68760. Physician/Medical the Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Lange ABBORING HASS Sundas 1 Yes 2 No 3 Probably 4 4 Unknown signed b Records, þ Completed 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to completion of cause of death? Colon Corcinona. pege 2 s certificate 1 Yas 2 10 1 ☐ Yas 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funerel director, p 25. Was casa rafarrad to medical exeminar? Be 26. Plece of Death (Chack only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Mursing Homa 5 Rasidance 6 Other (Specify) Medical Certification: To 27. Mennar of Death 28a. Data of Injury (Month, Dev Year) 28b. Time of 28d. Dascribe how injury occurred 28c. Injury at Work? 1 Naturai 5 Panding investigation None 1 ☐ Yas 2 ☐ No 2 Accidant 3 Suicida 6 Could not be 28e. Place of Injury - At home, farm, straat, factory, office building, atc. (Specify) 28f. Location (Streat end Number or Rural Route Number, City or Town, State) 4 Homicida 1 Dertifying Physicien: To the best of my knowledge, deeth occurred at the time, dete end placa, and dua to the causa(s) and mannar as stated.
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date end place, and dua to the causa(s) and menner stated. 29e, Cartifier 29b. Signature and titla of certifiar 29d. Data signed (Month, Day, Year) 29c. Licansa number 023889 30. Nama and addrass of person who complated cause of death (Itam 23a) (Type, Print) John C. ATRABACM, MD, 94FWAShington AVR, CKlestestown, Wed 21420
31. Data filed (Month, Day, Year)

JUL 1 6 1999 Service G. Son, V. 31. Data filed (Month, Day, Year) State 16 Registrar

DHMH 16 Rev 6/95



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

24388 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** July 9,1999 9:59 a.m. Blaine Sigler MacDannald /Medical 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Kent 300 Hadaway drive Apt. 9 D Chestertown | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | August 13,1915 5. Sociel Security Number 7. Age (In yrs. lest birthday) Funeral 9. Birthplece (Stete or Foreign 1₽M 2□F Peimsylvania 83 Yrs. 207 09 0667 Director Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 No 2 No Maryland Kent Chestertown 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 6 USA 300 Hadaway Drive Apt 9 D 21620 "natural", or items 23a 12. Was Decedent Ever In U,S. Armed Forces? Y⊟ Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1□ Yes 2□ No Specify: þ of Yes, Give Year or Dates WWII Special white 3 ☐ Widowed 4 ☑ Divorcad Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. other than "r Elementary/Secondary (0-12) College (1-4or 5+) Pharmacutical Clerk nent of Health and Mental H, nt: If item 27 is marked .... 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Malden Surneme) Bertha M. Weaver James Guy MacDannald 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 3302 E. Presidio Rd Tucson, AZ 85716 Carol E. Drown 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/16 Md. Veterans Cemetery Hurlock, Md. 21. Signeture of Funeral Service Line 22. Name and Address of Facility Fellows, Helfenbein, & Newnam Funeral Home Caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. cauga en 23a. Part1. Entire the disease, or compli-shock, or heart failure. List only or Approximete Interval Between Onset end Death **Physician** Lower G.I. Blend /Medical Immediate Cause (Final <24" disease or condition resulting in death) Examiner Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed nding physician and use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of): P.O. Box 68760, Due to (or es a consequence of): Pert II. Other eigniffcant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? DM TypeII, AFib, BPH, COPD, HH, 12 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to Completed Puby, Glancoma Poriphoral Vase Py 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Dey Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation **Naturai** 2 Accident 1 Yes 2 No 3 Suicide 6 Could not be 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, and due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of exeminetion and/or investigetion, in my opinion, death occurred at the time, dete end placa, and due to the ceuse(s) and menner stated. 29b. Signature and title of cartifler 29c. License number 29d. Date signed (Month, Dey, Year) D 50996 30. Name and address of person, who completed cause of death (Item 23e) (Type, Print) Stod day d Neil 100 Brown St. Chestortown IND MD 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

JUL 1 3 1999



### Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** July 16, 7:00 p.m. Alice Stafford Moore 1999 /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Corsica Hills Nursing Center Centreville Oueen Anne's If Under 1 Yaar | if Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (Stata or Foreign Country) 6. Sex **Funeral** 1 ☐ M 2 💢 F 93 Director July 28, 1905 Grascosville, MD 216-10-3906 Usual Residence of Decedant the Manyland 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits **ehow** 7 is marked other than "natural", or items 23s or 28s-f short treumstic svent, the Medical Examinar must be notified at 1 ☐ Yes 2XXVo Directo Maryland Kent Rock Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? PO BOX 271 21661 USA Funeral death 12. Was Decedant Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Maxican, Puarto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filled within 72 hours effer.
Department of Health and Mentel Hygiene.
Important: if item 27 is marked other than "natural", or item eny injury or other treumatic svent, the Medical Exempted Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 🕅 No Specify: White Š 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT usa retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clothing Seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumame) Charles R. Stafford Alice M. Stafford 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Virginia Rhoades/Daughter 152 Kings Highway, Lewes, DE 19958 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, crematory or other place) Data 20c. Location - City or Town, State 1 Burial 2 □ Cramation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Chesterfield Centery 7/21/99 Centreville, Maryland 22 Nama and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 21. Signature of Funtral Service Licensee 130 Speer Road, Chestertown, Maryland 21620 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical immediate Cause (Final mindisease or condition resulting in death) Examiner Examiner requires that the death certificate be executed physician and the burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseasa or injury that initiated events resulting in death) Last or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical 98 esn 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. signed by t 1 □ Yes 2 No 3 Probably 4 Unknown Completed by 24b. Wera autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 200 1 Yes certificate or Attending Physician: Be 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Matural 5 Pending efter death. 1 Tes 2 No invastigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours e Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

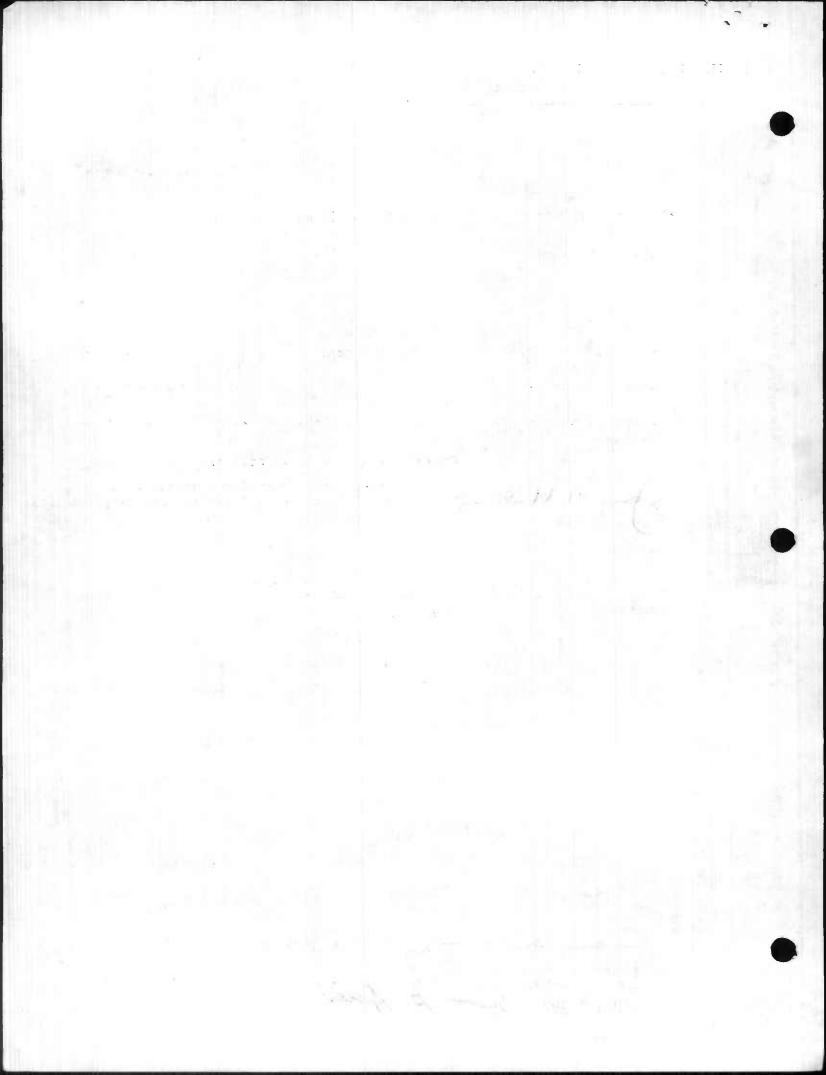
2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartifier 051735 199 MD 36. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Frederick relboy, 6602 Church Hill Road, Suite 200, Chestertown, MD 21620 31. Date filed (Month, Day, Year) 32. Registrar's Signature State عسمعووي 2 0 1999 Registrar

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM#	1 PER MD G775 9-1-99 W		Cer	tificat	e of Death	2. Date of Da	Reg. No.	9 24	Tima of Deeth
Physician		CHARLES HAMI	ANN			Month	Day	Year	
/Medical	CHARLES AT	misceau				3047		11	23:15
Examiner	4a Facility Name (If not institution, give	street and number)			4b. City, Town, or	Location of Deat	h 4c. County	of Death	
	Good Samaritan	Hospital				ore Cit	у		
Funeral Director	5. Social Security Number 6. Se 212–32–1044 11	7. Age (In yrs 74	. last birthday) Yrs.	If Under Months	1 Year If Under 24 Hrs Days Hours Min	8. Date of Bir (Month, De Oct.	th Year) 1924	9. Birthplace Country) Maryla	(State or Foreign
9	10a. State 10b. County	10c. C	ity, Town or Loc	cation				10d I	Inside City Limits
ven the Maryli or 28a-f sho be notified at Director	Maryland Baltime		andalls	town	(Granite)			1	1 ☐ Yes 2 ☐ No
after death with the Maryla or thems 23e or 28e-f shor miner must be notified at r Funeral Director	10e. Street and Number 2916 Offutt Road	d			21133			What Country? d State	
9 6 5	11. Marital Status  1 Never Merried 2X Married  3 Widowed 4 Divorced	12. Wes Decedent Ever in the Armed Forces?  1 ☐ Yes 2 M No if Yes, Give Year or Dates:			lent of Hispanic Origin? (Sity Cuban, Mexican, Puer 2 No Specify:	Specify Yes or No to Rican, etc.)	Specify	e - American Ir ck, White, etc.	
L Z I Z I S - U ed within 72 ho ygjere. we then "neturn it, the Medical. Completed	15. Decedent's Ed		16a. Deced	ent's Usue	Occupation	al in a	16b. Kind of Bu	usiness/Industr	у
within 7	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	OO NOT us	rk done during most of wo se retired)	rking			
The state of the s	12th Grade	3 +	Dair	y Far	mer		Self-	Employe	ed
	17. Father's Name (First, Middle, Last)					me (First, Middle	, Maiden Sumem	10)	
m ages m	Thomas Armistead	Mann			Sarah	Margaret	Amelia	Rinker	
ary is should nd Mer marks marks To	19s. Informent's Name/Relationship (7	iona Print)	10h Mailin	n Address	(Street and Number or R				
Ma d 2 a f la a f la a f la a	Mrs. Jane A. Mann				Road; Randa				
C = 01 6	20a. Method of Disposition		Place of Dispos			Date	20c. Location -		
Definitions, yamit, Pages 1 a Japantment of Hea mportant: if liven my injury or other ands.	1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removel from State	cemetery, crem	natory or o	ther place)				
Demit. Depart Import any inj	21. Signeture of Funeral Service Licent	1 & S	Lo	ring	d Address of Facility Byers Funer iberty Road;				. 1 21122
Physician /Medicat Examiner	Immediate Cause (Final disease or condition resulting In death)	s. Se	or as a conseq	uence of):					set end Death
rificate be assouted rificate be assouted on physician and as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last	c. Pulmon	ь.	uence of):	shock				
andir use		d. Course	s per	L	Succe				
d for atte	Part II. Other significant conditions co	ntributing to death but not re	sulting in the un	darkina e	auce given in Part I	23h Did	tohacco use cor	ntribute to the	causs of death?
that the ned by the detache									y 4□Unknown
The law requires that the death centrale has been signed by the attending page 2 should be detached for usa Completed by Physiclan/N							an autopsy ormed?	availab	autopsy findings ble prior to ation of cause th?
vical net significate has t lifector, page 2 s						10	Yas 28 No	1 □ Ye	s 212 No
stor, peter, pet	25. Wes case referred to medical				26 Place of De	ath (Check only			
ireci in	examiner?	Hospital: 12 Inpatient 2	] ER/Outpatien	3 DO	Other		idence 6 Oth	or (Specific	
Physic rithis contail direction of the To	27. Manner of Death		28b. Time of				how injury occur		
Lat or Attending Physicien: The start death.  In Director: After this certificate led in by the funeral director, percentification: To Be Co	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	Injury	M	8c. Injury at Work? 1 Yes 2 No				uda Mumbar
3 2 5 5 O	4 Homicide determined	28e. Place of Injury - At I building, etc. (Speci	ify)			City or To	(Street end Numb wn, Stete)		
he Hospin 24 hours he Funer pletely fill	29a, Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	reician: To the best of my kniner: On the basis of examinand manner stated.	owledge, death ation and/or inv	occurred estigation,	st the time, date and place in my opinion, death occ	e, and due to the urred et the time,	cause(s) and ma date and place,	annar as stated and due to the	J. cause(s)
To the To the Com	29b. Signeture and title of certifier	7		290	. License number		29d. Date signer		
	20 Name and address of	acole	~ ^ ^	2 int	P 113 9	0	Sucy	29,1	999
	30. Nama and address of person who c	SKA, MD	5601	(Ana	THE FAUEN	BWA	BACT	nore,	193163
State i	31. Date filed Alogic Day, Year 1999	35 Registrant Sign	atury.	apor					

Registrar



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 24391

MEND# 4C 7/16/99 AACO HEALTH DEPT CM Department of Death

1	AMEND#	4 C	7/16/99 AACO	HEALTH D	EPT CM	<b>Gertifi</b>	cate of	Death		Reg. No.	) 6	4001
		1, 0	Decedent's Name (First, Middle, La						2. Date of De	eth	Year	3. Time of Death
	Physician /Medical		John Nie	SZ					July	/ 12		17:22
	Examiner	4-	Facility Nama (If not institution, given	a street and number)			4	tb. City, Town,	or Location of Deat		of Death	0
			niversity of MAR	yland Medic	al Cente	r 22	S. Greene	estr.	Baltimar		timor	ce City
П	Funeral Director		6. 8 16-50-3521	Sex 7. Age	(In yrs. last birti		Under 1 Year onths Days		Hrs. 8. Data of Bir Min. (Month, Di Aug 30		9. Birthplac Country; MD	ce (State or Foreign
1	D .		uel Residence of Decedant a. Stata 10b. County		10c. City, Town	or Loontin	_				l and	Secreta Ob. 4 limin
	the Maryland 28s-1 show offilised at ector		MD Anne Aru		Arnold	FOI LOCAIIO	"				100.	Inside City Limits  1 ☐ Yes 2 ☑ No
	with the Maryla or 28a-f sho be notified at Director	100	a. Street and Number	nder	ALIIOIU	14	Of. Zip Code			10g. Citizen of 1	Min at Country	
	0 8 0		590 Melissa Cou				2101	12		USA		
	ther death or thems 234 cliner must	11.	Marital Status	12. Was Decedent En Armed Forces?	1922	13. Was I	Decedent of H s, specify Cuba	lispanic Origin an, Mexican, P	? (Specify Yes or No uerto Rican, etc.)		ce - American ck, White, etc.	
21215-0020	72 hours after natural", or the dicel Examina eted by Fu	2	1 Naver Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Giva Yaar or Dates:	/ietnam War	101	es 2 No	Specify:		Specify	White	:
2	Tan Tanto		15. Decedent's E (Specify only highest gra		16a.	Decedent's (Give kind	Usual Occup	ation during most of d)	working	16b. Kind of B	usiness/Indus	itry
12	be filed within 72 ho tal Myglene. I other than "naturn event, the Medical.  Be Completed	E	Elementery/Secondary (0-12)	College (1-4or 5+	)					Dont		
75	Hygie ther to	17	Fathar's Name (First, Middle, Last	2		wner	or ber	ital La	D Name <i>(First, Middle</i>	Denti		
5			Jacob Niesz	,			-	Mary		, Meloen Sumen	10)	
2	marked marked amatic es	-	a. Informant's Name/Relationship (	Type Print)	10h	Mailing Ad	Idraes (Straet		r Rural Routa Numb	er City or Town	State Tin Cu	orde)
N S	and 2 sailth ar n 27 is er trau		Donna Niesz/Wif		100.				Arnold,			~~,
é.	- £ 5 fs	208	. Method of Disposition		20b. Place of	Disposition	(Name of		Date	20c. Location		ı, State
Ê.	Pages net if the iry or of		1 Burial 2 Cramation 3 C				y or other place lemoria		July 16	Davids	onvill	e. MD
-	Departm Departm Importar sny Inju	21	Signature of Fineral Service Lider		Lakeli	22. Na	na and Addre	ss of Facility	,			
m	SOL SOL		MALL	( <		Ba	rranco	& Sons Ritchi	, P.A. Se	verna Pa na Park	ark Fur	neral Home 1146
		23	Entar tha disaase, or com	plications that caused t	he death. Do n	and the second					A	pproximata
F	Physician	1	gaca, or haart failura. List only	ona cause on aach line	9.						O	nterval Between Inset and Death
7	/Medical	Imi	mediata Cause (Final eese or condition	Lun	a C	anc	or				1	
'	Examiner	ras	sulting in death)		ue to (or as a c		_					
	ē E											
	rificate be executed no physician and as the burial-transit	Se	quantially list conditions, ny, laading to immadiata	D. D	ue to (or as a co	onsequenc	e of):					
0,	Sign Sign Sign Sign Sign Sign Sign Sign	cat Ca	ny, leading to immediate use. Enter Underlying use (Disaese or Injury								1	
68760,	physicial streets be edical	tha res	t initiated events uiting In death) Last	D	ue to (or as a co	onsequenc	e of):					
×	2 2 3			d							i	
Вох	atten for u										1	
0.	ss that the death cer igned by the attendir be detached for use by Physician/A	Par	t II. Other significant conditions of	ontributing to death but	not resulting in	the underly	ying cause giv	en in Part I.				he cause of death?
0	y Pt				_					Yes 2 No	3 Probab	bly 4 Unknown
Records,	The law requires that the death ce cate has been signed by the attending page 2 should be detached for use Completed by Physician/									an autopsy		autopsy findings
00	should s								perfo	ormed?		able prior to pletion of cause ath?
He He	a has								10	Yes 2 No		res 2□ No
ē		25	Was case referred to medical					26 Dines of	Death (Check only		1 .01	65 2 140
>	hysician: The his certificate had director, page		examinar?	Hospital: Inpatient	t 2 ER/Out	nationt 3	DOA Oth	er	ng Homa 5 Resi		ner (Snecify)	
Division of Vital	5 5 8		Mannar of Death	28a. Date of Injury (Month, Day		ima of	28c. Injur			how injury occur		
0	e fun		1 Natural 5 Panding invastigation		rear) in	njury N		Yes 2 No				
N S	octo		3 ☐ Suicide 6 ☐ Could not b determined	28a. Place of tnjur building, etc.	y - At home, fan	m, street, f	actory, office		28f. Location ( City or To	Street and Number State	ber or Rural R	loute Number,
ā .	tal or Attending P is after death.  at Director: After ted in by the funeral Certification:		4 ETTORIGOE	building, etc.	(Specify)				City of 10	wii, State)		
	To the hospital of Attending Protection 24 hours after death.  To the Funeral Director: After completely filled in by the funer.  Medical Certification:		a. Certifiar (Check only one) Certifying Ph	ysician: To the best of ninar: On the basis of a and manner state	examination and	death occi Vor investig	urred at the tin pation, in my o	ne, date and p pinion, death o	lace, and due to the occurred at the time,	cause(s) and modate and place,	anner as state and due to th	ed. ne cause(s)
	Vithin comple		. Signature and two of certifier	200	\ .		29c. Licens	e number		29d. Data signa	ed (Month, De	ly, Year)
	->-0		1.1.12	111	TM	D	PII	735		-T. I.	12	1999
		30.	Name and address of person who	completed segme of the	ith (Item 23a) (I	Type, Print		. )		2019	10,	1171
		-	DEBRA M.	BENS	ME	22		PLEEL	JE 57. 7	BAUTI	MORF.	MD
	State	31.	Data filed (Month, Day, Year)	32. Pegistrar	's Signatura	1.						
	Registrar		JUL 1 6 199	9 Janes		7. 4	bour	/				

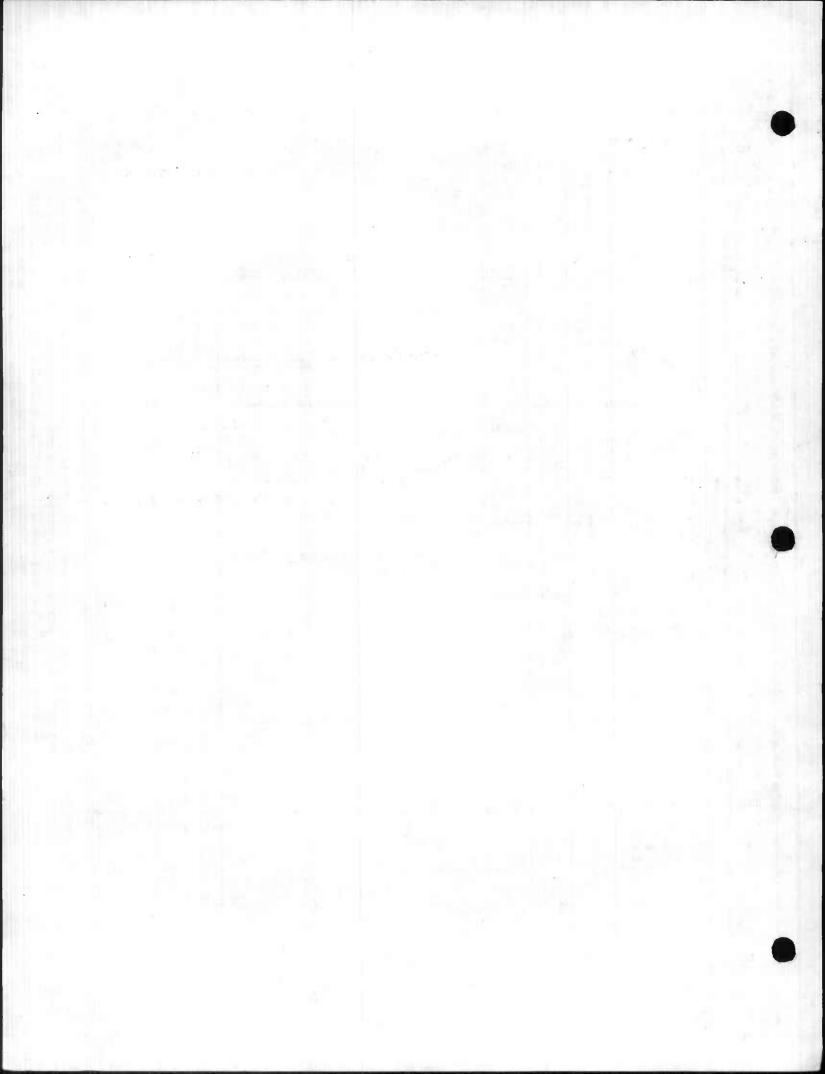
DHMH 16 Ray 6/95

### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Bertha 19. 1999 /Medical July 6:10 am 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chevy Chase Manor Care Nursing Home
5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Montgomery If Under 1 Yea 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1□M 2ØF Yrs. 78 Director October 22, 1920 Texas 466-30-6136 Uaual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director D.C. Washington, 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States
o- 14 Race - American Indian,
Black, Whita, etc. Funeral 2022 Klingle Road NW 20010 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status filed within 72 hours after Hygiene. Ther than "natural", or Ite 1 Yes 2X No
If Yes, Give
Year or Dates; 1 Never Merried 2 Merried Specify: Black Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled wit Department of Health and Mental Hygiene Important: if item 27 ie merked other tha eny Injury or other traumatic event, that p.006. 12 Housekeeper Private 17. Father's Neme (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Be Walter Ross Alice Littlefield 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2022 Klingle Rd NW D.C. 20010 Marian Johnson / Daughter 20e. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Mausoleum Fort Lincoln Cemetery 7/22/99 Brentwood Maryland 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility
Fort Lincoln Funeral Home Wellso 3401 Bladensburg Road Brentwood, Maryland 20722 rour 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Years Examiner Examiner physician and the burief-transit Sequentially list conditiona, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Box 68760 that the death certificate be by Physician/Medical Due to (or as a consequence of): 8 980 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. the Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown signed by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wea an autopsy performed? Completed has 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Care Sro vascula Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this n 24 hours after death.

Ne Funeral Director: After the pletely filled in by the funeral 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation or Attending 1 Netural 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide the Hospital 29e. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(a) and manner stated. (Check only one) within 2 29b. Signature and sets of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Musher 330 WISCOMSIN ona 31. Date filed (Month, Day, Year) 32. Flegistrar'a Signature State 21 Registrar

DHMH 16 Rev 6/95



Reg. No.

State of Maryland /	Department	of Health	and Me	ental Hygiene
	Certificate	of Death	7	Reg No

	Physic /Med Exami	ical
	unera	
anyland	show	

5. Social Sacurity Number 6. Sex Months Days 1 □ M 25 F 215-32-7107 59 Yrs. Usual Residence of Decedant 10a State 10c. City. Town or Location 10b. County MARYLAND ANNE ARUNDEL ANNAPOLIS Directo 7 is marked other than "natural", or items 23s or 28s-f traumetic event, the Manical Exement must be nother death with the 10e. Street and Number 10f. Zip Coda 1916 COPELAND STREET 21401 Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other transmission. 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No if Yes, Giva Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 1 □ Navar Married 2 □ Married 1 Yas 2 XNo Specify: by 3 Widowed 4 □ Divorced Completed 15. Decedant's Education 16a. Decedent's Usual Occupation (Specify only highast grada complated) (Giva kind of work done during most of working lifa. DO NOT usa retired) Elamantary/Secondary (0-12) Collega (1-4or 5+) 10th HOMEMAKER 17. Fathar's Nama (First, Middla, Last) GEORGE CREEK BESSIE SIMMS 2 19a. Informant's Name/Ralationship (Type, Pnnt) JOANN PARKER (DAUGHTER) 20b. Placa of Disposition (Nama of cematary, crametory or other plece) 20a. Mathod of Disposition Data 21. Signature of Funaral Sarvice Licensee 22. Name and Addrass of Facility Lavry **Physician** Immadiata Cause (Finel disaasa or condition rasulting in death) /Medical Sepsis Examiner Dua to (or as a consequence of): Examiner Gangrene attending physician and for use as the burial-transit Sequantially list conditions, if any, leeding to Immadiata cause. Entar Undarlying Causa (Disaasa or injury Due to (or as a consequence of): the death certificate be exect Box 68760. Diabetes Physician/Medical thet initieted avants rasulting in deeth) Last Dua to (or as a consequence of): P.O. Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, þ 8 Completed peen page 2 s certificate has 25. Was casa rafarrad to medical axaminar? Be Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 21 No 10 this funeral 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 1 DiNetural 28b. Time of Certification: 28c. Injury af Work? After t Hospital or Attending 5 Pending Invastigation after death. 1 Yas 2 No the f 2 Accident 6 Could not ba 3 Suicide 28a. Place of Injury - At homa, farm, straat, factory, offica building, etc. (Specify) 4 Homicide 24 hours 29a. Certifier Medicai completaly (Check only within 2 To the 29b. Signatura and title of certific 29c. License number 30. Neme and eddress of person who complated cause of daath (Itam 23e) (Type, Print) 1610 West St#110 Annapolis, Md. 21401 Brian S. Kahan, DO

1. Decedant's Name (First, Middla, Last) 2. Data of Death 3. Time of Death Month 15 1999 11:20 pm ELEANOR PARKER JULY 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death ANNAPOLIS NURSING & REHAB. CENTER ANNE ARUNDEL ANNAPOLIS 7. Age (In yrs. last birthday) If Under 1 Yaar If Undar 24 Hrs. 8. Dafe of Birth (Month, Dey, Year) Birthplace (Stata or Foraign Country) OCT. 11 1939 MARYLAND 10d. Insida City Limits Yas 2 No 10g. Citizen of What Country? US 14. Race - American Indian. Black, Whita, atc. Specify: BLACK 16b. Kind of Businass/Industry HOME 18. Mothar's Nema (First, Middle, Maidan Sumama) 19b. Mailing Addrass (Street and Number or Rural Routa Numbar, City or Town, State, Zip Coda) 1916 F. COPELAND ST. ANNAPOLIS, MD. 21401 20c. Location - City or Town, Stata \*\*Reduction 2 Cramation 3 Ramoval from Stata ADAMS CHURCH CEMETERY 7/20/99 LOTHIAN, MD. WM. REESE & SONS MORTUARY, P.A. Zavy J. Rees 821 WEST ST. ANNAPOLIS, MD. 21401

23a. Part1. Entar tha disaasa, or complications thet caused the death. Do not anter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart feiture. List only one cause on each line. Approximate Intarvel Between Onset and Death mo 4 mo 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings available prior to completion of cause of death? 24e. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yes 2 ☐ No 26. Place of Daath (Check only ona) Othar: 4 Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) 28d. Describe how injury occurred 28f. Location (Street end Number or Rural Routa Number, City or Town, Stata) 1 Certifying Phyaiclan: To the bast of my knowledga, death occurred et the time, dete end plece, end due to the causa(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date end plece, and due to the causa(s) and menner stated. 29d. Data signed (Month, Day, Year)

State Registrar

31. Data filed (Month, Day, Yaer)

JUL 1.9 1999

32. Registrar's Signatura

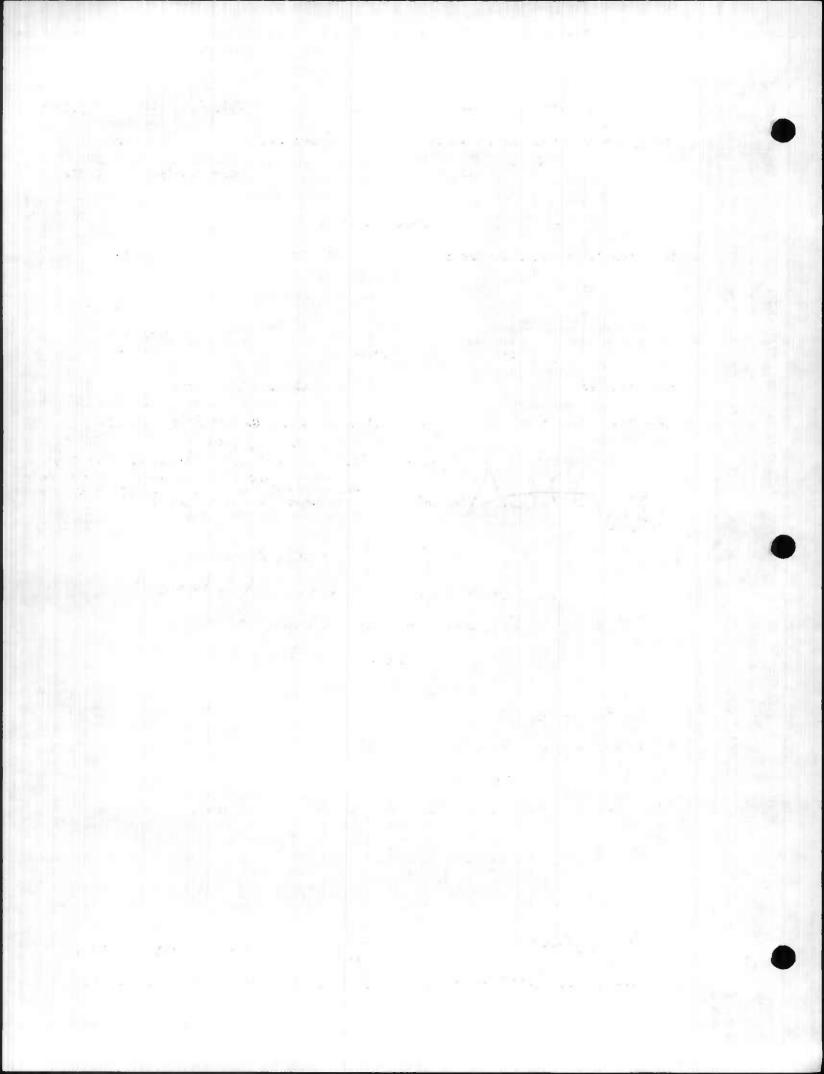
JUL 19 1999 James D. James

MINISTER TO COM

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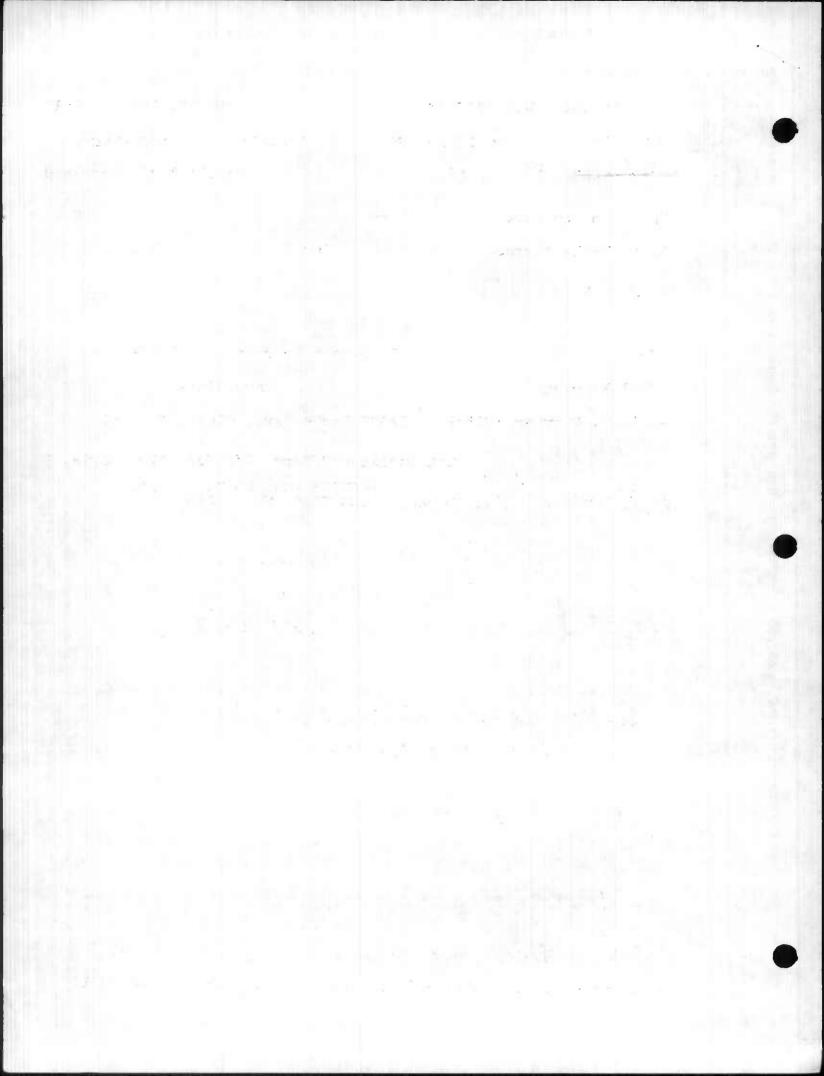
State of Maryland / Department of Health and Mental Hygiene 99 24394

					Ce	ertificate of	Death		Re	eg. No.		
		1. Decedent's Name (First, Midd	le, Last)	17.1					2. Date of Deat	_	V	3. Tima of Death
Physic		Nare	ndra	C.		Pant			July 17	, <sup>Day</sup> 1999	Year	5:05PM
/Med Exam		4a Facility Name (If not institution	n, give street and n	umber)			4b. City, Tow	vn, or Lo	cation of Death	4c. County	of Death	7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7
LAdill	11161	Shady Grove A	dventist	Hospita	a 1		Rockv	1116	2	Mont	comer	·v
Funana		5. Social Security Number	6. Sex		s. last birthday	If Under 1 Year	r   If Under 2	24 Hrs.	8. Date of Birth (Month, Day,		9	-
Funera Director		N/A	1፟∭M 2□F	75	Yrs.	Months Days	Hours	Min.	(Month, Day, January 24		Cou	place (State or Foreign ntry) India
		Usual Residence of Decedent							paridary 24	, 1724		Inula
land land		10a. State 10b. County	,	10c. C	ity, Town or L	ocation						10d. Inside City Limits
Mary Feh	ō				Danca 1	oro Indi						1 Yes 2 No
the the	8	10e. Street and Number			Dangaro	ore, Indi	.a		1:	0g. Citizen of 1	What Cou	ntry?
with po of	ā		one ID	Massa			0.70		'		dia	,
ath 23	Fa	456, 11th B. Ci			11.0		078	J-2 /C-	naife Van au Na			can Indian.
d 21215-0020 filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or flams 23a or 28a-f show ant, the Madical Examiner must be notified.	by Funeral Director	11. Marital Status	Armed F		0,5. 13.	Was Decedent of If Yes, specify Cub	ban, Mexican,	, Puerto	Rican, etc.)		ck, White,	
20 at 5	Y	1 Never Married 28 Mar	If Yes, G			1□ Yes 2₺ No	Specify:			Specif	V:	
Pont Do	D	3 Widowed 4 Divorced	1,54	Dates:	10.0					40h Kh d -40	Indi	an
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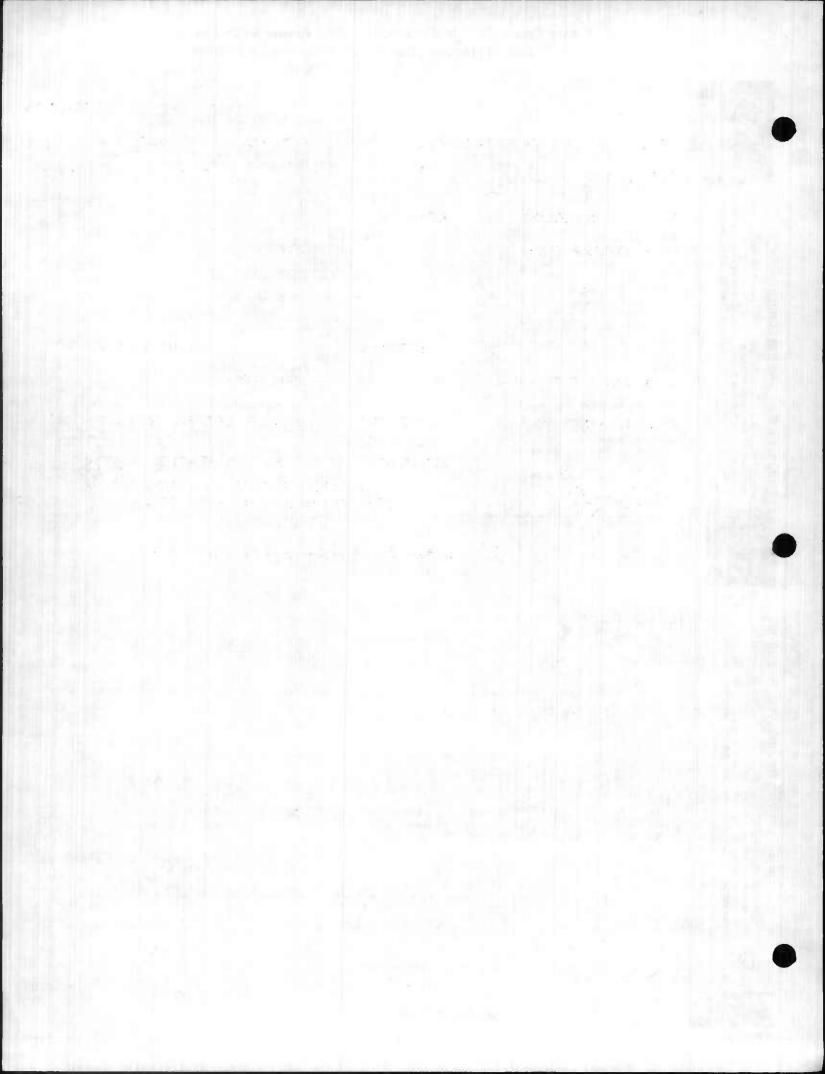
DHMH 16 Rev 6/95



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Ω.	25. W	/as casa referred to me caminar?  Yes 2 No enar of Death Naturel 5 P No enar of Death Suicident 6 C	M E	Hospital: 1 Inpal 28a. Data of In (Month, D	but not ras  VA  tient 2□  jury ay Year)	ER/Outpa 28b. Tim Injur	a undarlying causa g	28. Placa of De ther: 4 Nursing Nursin	24e. Wes perfo	en autopsymmed?  Yas 2 No  Ona)  denca 6 Oth how injury occur  Street and Numb	3 Probably  24b. Wara a evaliable comple of deatt  1 Yan  har (Specify)	utopsy tindings a prior to tion of causa 17
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edical Certification: To Be Completed by	25. W an 11 27. M 1 2 3 4 29a.	/as casa referrad to me caminar?    Yes 2   No eparar of Death     Naturel   5   P     Accidant   in     Sulcida   6   C     Homicida   Cariflar (Check only one)   2   Medical Medical	edical ending vestigation to be alarmined	Hospital: 1 Inpai  28a. Data of In (Month, D)  28a. Place of It building, 6	but not ras  VA  tient 2   jury ay Year)  njury - At hotc. (Spacifi	ER/Outpa 28b. Tim Injur oma, farm,	a undarlying causa g  LAR  tient 3 DOA  tient 3 DOA  28c. Injury M 15  streat, factory, office	28. Placa of De Iher: 4 Nursing Nursin	24e. Wes perfo	Yes 2 No en autopsy med?  Yas 2 No ona) denca 6 Oth how injury occur  Street and Numb wn, Stata) cause(s) and ma date end place,	3 Probably  24b. Wara a evaliable comple of death 1 Yau  har (Specify)  red  per or Rural Rob  annar as stated end due to tha	utopsy tindings a prior to tion of causa 17 s 2 No
ο.	25. W an 11 27. M 1 2 3 4 29a.	/as casa referrad to me caminar?  Yes 2 No enar of Death Naturel 5 P Accident in Suicida 6 C C Homicida  Cartiflar Check only 2 Mer	edical ending vestigation to be alarmined	Hospital: 1 Inpal 28a. Data of In (Month, D 28a. Place of It building, e	but not ras  VA  tient 2   jury ay Year)  njury - At hotc. (Spacifi	ER/Outpa 28b. Tim Injur oma, farm,	a undarlying causa g  LAR  tient 3 DOA  tient 3 DOA  28c. Injury M  15  streat, factory, office ath occurred at that investigation, in my	28. Piaca of De ther:  1 A Nursing Nur	24e. Wesperfo	Yee 2 No en autopsy med?  Yas 2 No ona)  denca 6 □Oth how injury occur  Street and Numb wm, Stata  cause(s) and me date end plece, 29d. Data signe	3 Probably  24b. Wara a evaliable comple of death 1 Yai  var (Specify)  red  per or Rural Roll  annar as stated end due to tha	utopsy tindings a prior to tion of causa?  s 2 No  No  Na Number,  cause(s)
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pietaly filled in by the funeral director, page 2 should be d edical Certification: To Be Completed by	25. W as 11 27. M 12 3 4 29a.	/as casa referrad to mexaminar?    Yes   2\   No     Separar of Death     Accident	edical ending restigation to be calarminad	Hospital: 1 Inpal 28a. Data of In (Month, D) 28a. Place of It building, 6	but not ras  VA  tient 2   jury ay Year)  njury - At hatc. (Spacifit of my knood examinal steted.	ER/Outpa 28b. Tim Injur oma, farm, wiedga, detion end/or	tient 3 DOA of the of y M 15 streat, factory, office that investigation, in my	28. Piaca of De ther:  1 A Nursing Nur	24e. Wes perfo	Yee 2 No en autopsy med?  Yas 2 No ona)  denca 6 □Oth how injury occur  Street and Numb wm, Stata  cause(s) and me date end plece, 29d. Data signe	3 Probably  24b. Wara a evaliable comple of death 1 Yai  var (Specify)  red  per or Rural Roll  annar as stated end due to tha	utopsy tindings a prior to tion of causa?  s 2 No  No  Na Number,  cause(s)

Registrar

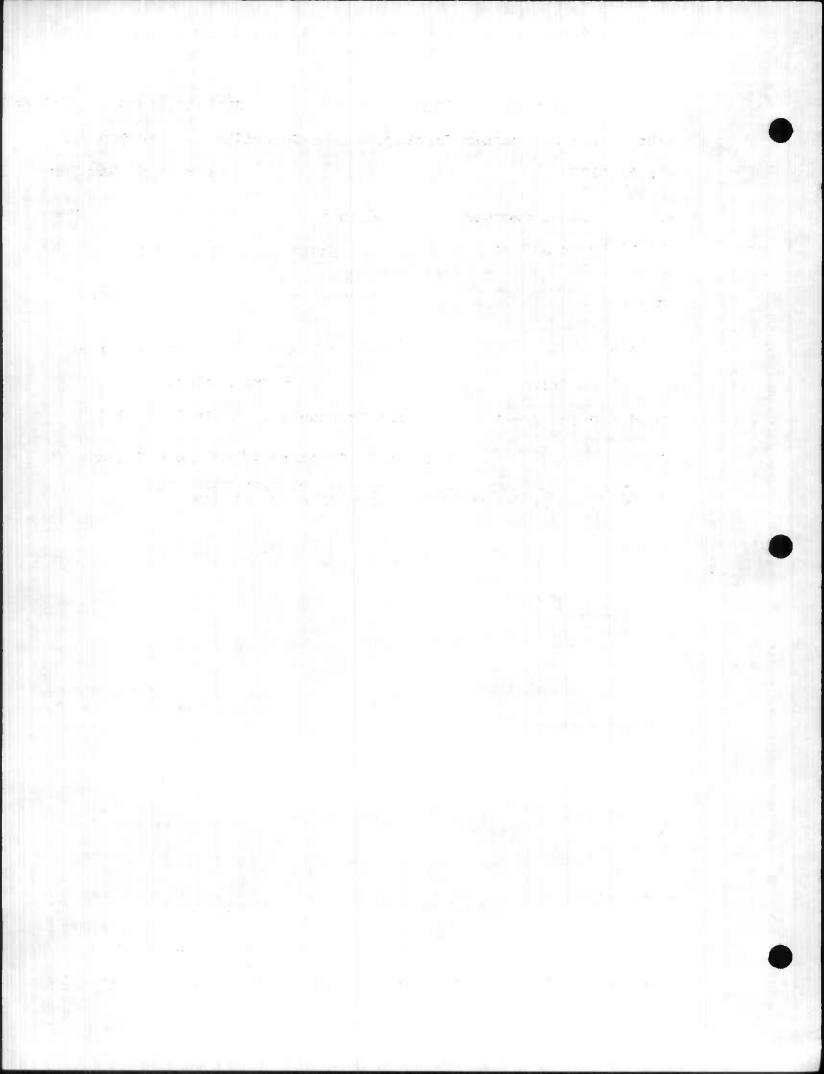


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 1 3 9 7

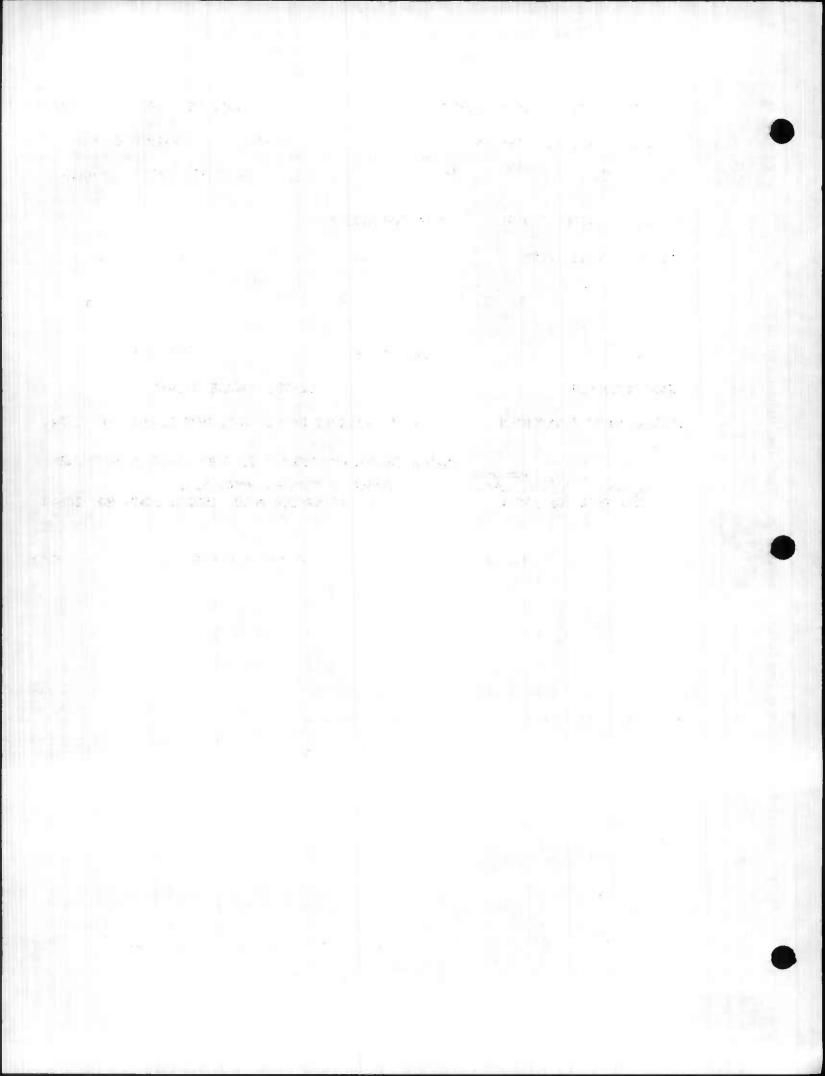
Certificate of Death

				Ceruno	ale of	Dealli	Reg.	No.		
	Physician /Medical	Decedent's Nama (First, Middle, Last GOT	) TLIEB PRI	CE			2. Date of Death Month JULY 14	Day 199	Year	Time of Death 11:30AM
	Examiner	4a Facility Name (If not institution, giva Hebrew Home of		shingtor		Rockv	ille		of Death ITGOME	ERY
	uneral irector	5. Social Security Number 6. Se 112-05-9177 Usual Residence of Decedent	7. Age (In yrs	Mont	hs Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye June 29,	1906	9. Birthplaca Country) New	York
Marylend	and show	10a. State 10b. County	Georges 10c. C	ity, Town or Location	lphi					Inside City Limits 1   Yas 2 □ No
with the	3a or 28 st be not	10e. Street and Number 10529 Truxton	Road	10f	Zip Code	783	10g.	Citizen of W	hat Country?	
020 urs after death	at, or tems 23a or 28a-f s Elaminer must be noutled by Funeral Director	11. Marital Status  1 Never Married 2 Married  3XX Widowed 4 Divorced	12. Was Decedant Evar in U Armed Forces? 1 ☐ Yes 2∑ No If Yes, Give Year or Dates:		ecedent of H specify Cube s 2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecity Yas or No- Rican, atc.)	Biaci	American lik, White, etc.	
	"natural	15. Decedent's Edu (Specify only highest grad Elemantary/Secondary (0-12) 8 th	cation e completed) Collega (1-4or 5+)			eation during most of work d) lesman			siness/Industr	
laryland 212 2 should be filed withing end Mental Hygiena.	atic event	17. Father's Name (First, Middle, Last)  Albert Pri	ce				e (First, Middle, Mei L Hillma		9)	
	27 le ma er trauma	19a. Informant's Name/Relationship (7) Daniel Price					Adelphi			
Baltimore,	rrportant: If fem 27 any injury or other to once.	20a. Method of Disposition  1 Disposition 2 Cremation 3 DSF 4 Donation 5 Other (Specify) 21. Sometimed Funeral Service Logical	Ramoval from Stata Be	Placa of Disposition cametery, cremetory eth David	or other plead  Cem  a and Addre	etery 7,	/15/99Lo	ng Is	City or Town,	
m is	E S S	23a. Part1. Entar the Ill ease, or compleshock, or heart sullure. List only o	Mouro	ROC	CKVIL	LE, MD	HOME, 20850			proximata
/Mo	edical edical iminer xeminer	resulting in dealth	o	Or as a consaquence	of):	F PAN	ICREA	S	( )	YEAR
OX 68760, h certificate be axecuted	ending physician and use as the burial-transit	Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disaasa or injury that initiated events resulting in death) Last	Due to (-	or as a consequence	of):					
D. the deat	d by the attentached for Physicia	Part II. Other significant conditions con	ntributing to death but not ra	sulting in the underlyi	ng cause giv	ren in Part I.				e causs of death?
dS, P.	be d								3 Probabl	ty 45 Unknows
I Records, P.O. Bo The law requires that the death	sata has been si page 2 should I						24a. Was an a performed	1?	availat	ble prior to ation of cause
of Vital P	ector.	25. Was casa rafarrad to medical examinar?	Hospital:		Oth	on A.	1 ☐ Yes	\$ No	1 □ Y€	es 2 No
\$ o	£ 00	27. Magner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	yat k? Yas 2 No	me 5 ☐ Rasidanc 28d. Dascribe how					
Divis Hospital or After	To the Funersi Director: After th completely filled in by the funeral Medical Certification:	3 Suicide 6 Could not be determined	28a. Place of Injury - At I building, etc. (Special	ify)			28f. Location (Strea City or Town, S	Stete)		
he Hosp in 24 hos	pletely fill		sician: To the best of my known ar: On the basis of examination and manner stated.		tion, in my o	pinion, death occur	red at tha time, date	end placa, s	and due to the	e cause(s)
To the I	Tot	29b. Signature and titing of common	lm.D.		29c. Licens				(Month, Day	
7 5	•	30. Nama and addrass of person who co	ompiated causa of death (Ita	m 23a) (Type, Print)	Ross	RD G	Jockvil	LS A	177	0852
	State	31. Date filed (Month, Dey, Year)	32. Registrar's Sign	ature 6	,			7		

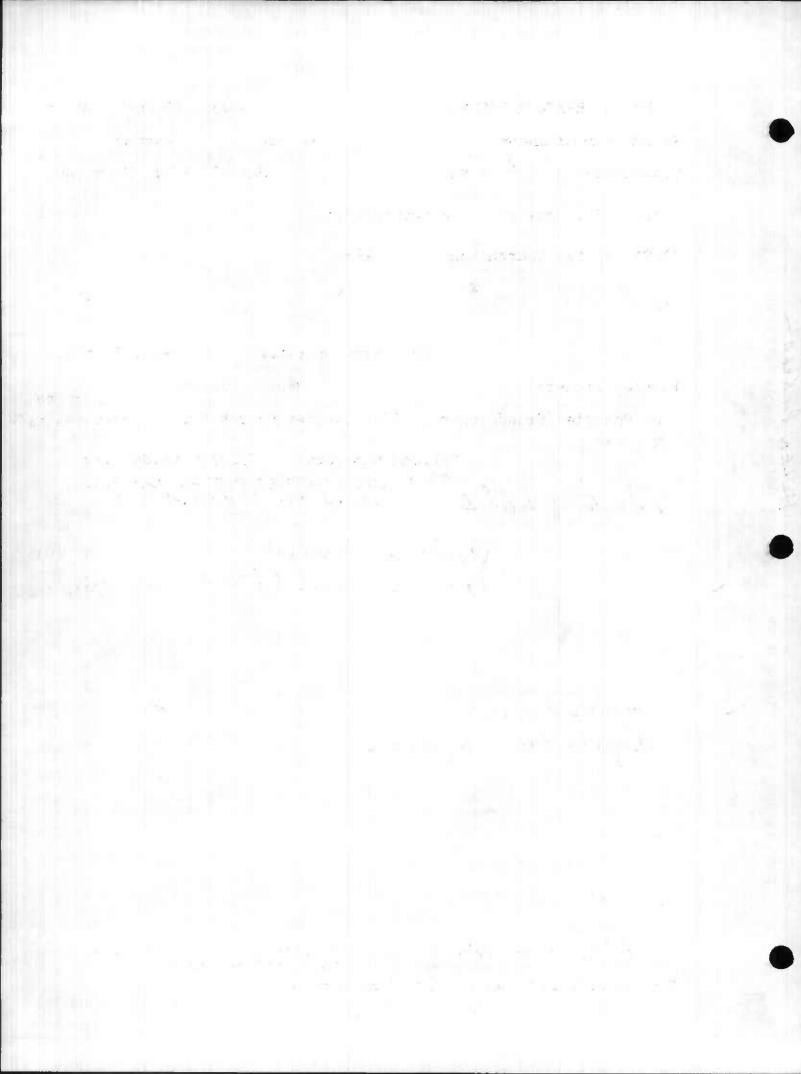


State of Maryland / Department of Health and Mental Hygiene 9 9 24398

				C	ertificat	e of	Death			Reg. No.			
		1. Decedent's Name (First, Middle, Last	0						2. Date of De		Veer	3. Tir	me of Death
Physic		LUCY CORENE T	OLSON PROUT						JULY 2	2, 1999	Year	12:	23 PM
/Med Exam		4a Facility Name (If not Institution, give					4b. City, To	wn, or Lo	cation of Deat			1	
LAGIII	HIEI	SOUTHERN MARYLAND	HOSPITAL				CLINT	CON		PRINC	E GEO	RGE	
Funera		Social Security Number 6. Se		last birthda	y) If Under		If Under	24 Hrs.	8. Date of Bir (Month, De		-		tate or Foreign
Directo		225-16-1101 15 Usual Residence of Decedent	□M 2⊠F 77	Yrs.	Months	Days	Hours	Min.	JUNE 1	7, 1922	VIR		
/land		10a. Stete 10b. County	10c. Ci	ty, Town or	Location						1	Od. Insi	ide City Limits
he Man 28a-f ah cotthed	Director	MARYLAND PRINCE G	EORGE FO	RT WA	SHINGT					10g. Citizen of	Mines Court		Yes 2□No
death with the Maryland rms 23e or 28e-f show	rai Dir	11707 HICKORY DRI			207	44				UNITES	STATE	S	
9 4 2	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	J,S. 1	3. Was Dece If Yes, spe 1  Yes	cify Cub	an, Mexican	gin? (Spe i, Puerto i	cify Yes or No Rican, etc.)		ce - Americack, White,	etc.	an,
72 hours aft natural; or	eted	15. Decedent's Edu (Specify only highest grad	ication le completed)	(Gi	cedent's Usu	rk done	during most	t of worki	ng	16b. Kind of E			
A 1 A 15-00 A 0 d within 72 hours af giene. If then 'natural', or then 'natural', or the Moule at Earth	Completed	Elementery/Secondery (0-12) 9th	College (1-4or 5+)		EWIFE	se retire	d)			PRIVAT	E.		
Hygilled Hygill	Ö	17. Father's Name (First, Middle, Last)					18. Mothe	r's Name	(First, Middle	, Maiden Suma	me)		
Mental Mental Mental	D Be	WALTER TOLSON					BERTI	IA MC	NROE I	OLSON			
d 2 should be file the and Mental Hy 7 is marked other traumatic event	10	19a. Informant's Neme/Relationship (7)	vne Print)	19b Me	ailina Address	(Street				er, City or Town	. State. Zic	Code)	
id 2 sho id 2 sho ith and if is m traum		GLORIA PROUT / DAU			07 HIC					SHINGTO			0744
1 and Health em 27 other tr		20a. Method of Disposition	20b. I	Placa of Dis	sposition (Na	ne of			Date	20c. Location			ate
mit. Pages 1 ar partment of Hea portant: If Item: y injury or othe		1 Buriai 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  22. Name and Address of Facility											
permit. Page Department of Important: If any injury or		21. Signature of Funeral Service Licens LEON THORNTON	3		THORN 3439 I	'ON	FUNERA	AT HO	ME, P.	A. DIAN HEA	n. m	20	0640
/Medical		Immediate Cause (Final disease or condition resulting in death)	a. ADE NOCARO Due to (		M A sequence of):	OF	PA	NCI	REAL			3	YEAR
ertificate be executing physician and	siciar siciar e buri	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in deeth) Last	с		sequence of):			_			1		
o the office of for us													
the de	ysic	Part II. Other significant conditions con	ntributing to death but not res	sulting in the	underlying o	ause gi	ven in Part I		23b. Did	tobacco use c			use of death?
es that the deeth cigned by the ettenc	by Ph	ACUTE ON CH	RONIC RE	NAL	FA	11	URE.		1	Yes 2 No	3 □ Pro	bably	4 Unknow
aw requir	s been s 2 should pieted	ENCEPHALOPAT	HY DIF	BE	Z-3 T	^	NELL	ITU	nord.	s an autopsy ormed?	av	/ailabie	n of cause
	Co								10	Yes 2 No	1 [	☐ Yes	2□ No
ician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	112-1			-1-		of Death	(Check only	one)			
Physic this co	2	1 ☐ Yes 2 No		ER/Outpat		DA		-		idenca 6 □Ot		(y)	
Attending Physician: or death. ector: After this certific by the funeral director,	ation:	27. Manner of Death  1 ⊠Naturai 5 ☐ Pending 2 ☐ Accident investigation	28a. Dete of Injury (Month, Day Year)	28b. Time Injur	of a	8c. tnju Wo 1	ry at rk? ] Yes 2 □		28d. Describe	how injury occu	irred		
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be determined									Number,		
24 hours P Funers letely fill	edical	29e. Certifier (Check only one) 12 Certifying Physical Exami	sician: To the best of my knowner: On the basis of examine and manner stated.	owledge, de ation and/or	eth occurred investigation	et the ti	me, date en opinion, dea	d plece, a	and due to the ed et the time	cause(s) and n , date and place	nannar as s , and due t	itated. o the ce	ouse(s)
To the To the	Me	29b. Signeture and title oncertifier	la Guh	· M.		. Licen	se number	116		29d. Date sign	ed (Month,	Day, Yo	1999
ŗ		30. Name and address of person who co	9 M.D. 89	726	woo	DY	ARS	b p	0 A D	# 5	01	V	
St	tate	31. Date filed (Month, Day, Year)	32. Registrar's Sign		6 73	pa	de)				-		



	Certificate of Death	Reg.	No.	1.000								
Physician		2. Date of Death Month	Day Yaar	3. Time of Deeth								
/Medical	HELEN REBECCA PICKERAL  4a Facility Name (If not institution, giva straat and number)  4b. City, Town, or Loc	-	20 1999 4c. County of Deat	8:30pm								
Examiner	Civista Medical Center LaPlata	ALION OF BOARS	Charles	·								
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If U r 1 Y r II Lindar 24 Hrs.	8. Date of Birth (Month, Day, Ye		nplace (Stata or Foreign untry)								
Director:	214-28-4455 88 Jur	ne 27,19	911 Mar	yland								
ž_	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Insida City Limits								
23a or 28a-f ahow unt be not red at al Director	MD St. Mary's Mechanicsville			1 ☐ Yes 2 N No								
Je C	10e. Sfreef and Number 10f. Zip Code	10g.	. Citizan of What Co	untry?								
aiD	27094 Baptist Church Road 20659		USA									
Funeral Director	11. Marital Status  12. Was Decedant Evar in U,S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto R	city Yes or No- lican, etc.)	14. Raca - Amer Black, White									
by F	1 □ Navar Marriad 2 □ Merried 1 □ Yes 2 ☒No If Yas, Giva 1 □ Yes 2 ☒No  YŒWidowed 4 □ Divorced Yaar or Dates:		Specify: Wh	ite								
8	15. Decedent's Education 16a. Decedent's Usual Occupation	168	b. Kind of Business/	industry								
plet	(Specify only highast grada complated) (Giva kind of work done during most of workin life. DO NOT use retired)  Elementary/Secondary (0-12) Coilege (1-4or 5+)	ng .										
Completed	6 Explosive Operator		Federal	Govt.								
Be	17. Fether's Name (First, Middle, Last)  18. Mothar's Name											
2	39	Pickera		200650								
any injury or other traumetic event, the Mannet.  To Be Comp	196. Informent's Name/Relationship ( <i>Type, Print</i> )  Janet Wheatley/Granddaughter 27094 Baptist Chur											
ome	20a. Method of Disposition  20b. Placa of Disposition (Nama of cematery, cramatory or other placa)		c. Location - City or									
5	1 Li Buriai 2 Li Cremation 3 Li Hemoval from State	/23/99 1	Waldorf,	MD								
- N	· · · · · · · · · · · · · · · · · · ·											
4 8	21. Signature of Funeral Servica Licensee MOOS/7 22. Name and Address of Facility AREHART – ECHOLS FUNERAL HOME P P.O. BOX 567 LA PLATA, MD 2064											
	23a. art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or hear failure. List only one cause on each line.			Approximate Intervai Between								
n of				Onsat and Death								
caí ner	Immediate Cause (Final disaasa or condition resulting in death)  a. Ventricular fibrillation	<u> </u>		immediate								
ē	Cougestive Heart fail	ure		5urs.								
dical Examiner				34.3.								
E	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury											
dical Examir	Cause Crisease of Injury that initiated events resulting in death) Last  Due to (or as a consequence of):											
Me	d											
clar	Pearly Other desidence and Management of the Control of the Contro	Only Distants	and the same and the state of t	to the name of death?								
Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	1 Yes		to the cause of death?								
ру Р	Marcies Metterns											
Completed by Physician/Me	Drabetes Mellitus Organic Brain Syndrome	24a. Wes en e performe	d? 8	Were autopsy findings available prior to completion of ceusa								
Be Completed				of deeth?								
S		1 ☐ Yes	2 No	1 ☐ Yes 2 ☐ No								
) Be	25. Was case referred to medical examiner?  Hospital: Continue of Death Continue of		A Florida	-W.A								
Ë	27. Manner of Deeth 28a. Date of Injury 28b. Time of 28c. Injury at 2	ne 5 Residence 8d. Describe how	e 6 Other (Specialized	ciry)								
completely filled in by the funer  Medical Certification	1 ☑Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident Investigation M 1 ☐ Yes 2 ☐ No											
# E	- T	8f. Location (Stree City or Town, S	at and Number or Ru Stata)	aral Routa Number,								
Ce	editing, etc. (epocity)											
Ica	29e. Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, a Check only and Check only control of examination and/or investigation, in my opinion, deeth occurred at the time, dete and place, a control of examination and/or investigation, in my opinion, deeth occurred at the time, dete and place, and the control of examination and/or investigation, in my opinion, deeth occurred at the time, dete and place, and the control of examination and/or investigation, in my opinion, deeth occurred at the time, dete and place, and the control of examination and/or investigation, in my opinion, deeth occurred at the time, determined at the ti											
Med	one) and manner stated.  29c. License number	29d.	. Date signed (Month	n, Day, Year)								
	1/// 1/1/01	1	1/2/10	9								
	D - 0052741	ne Center	1/2/19	/								
ì	30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 120/0 01d 1.11											
	Caroline J. Caine, MD Suite 100, Waldorf, Maryland 2060											



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4400 Certificate of Death 3. Time of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 1999 Month Pinder 1357 4c County of Death ANN July DOYCE 4b. City. Town, or Location of Death 4a Facility Name (If not institution, give street and number) PRINCE GEORGES COUNTY HOSPITAL 5. Social Security Number 6. Sex , 7. Age (Irryrs. last birthday) If Under 1 Year PRINCE GEORGES heverly If Under 24 Hrs. 6 Date of Birth Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) Days 214-60-925 1□M 20 F Oct. 06, 1955 Maryland 43 Yrs Usual Residence of Decedant 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 Yas 2 No PRINCE Georges Landover 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Avenue 20785 45 Warken 13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, Whita, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 2 No 1 Never Married 2 Married 1 Yes 2 1 Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Cotlege (1-4or 5+) Elementary/Secondary (0-12) Entrepreneur PROVIDER Cake 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Elsie Robinson, SR, Elsie Mae Cheste 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Benjanin Nathaniel Chester 19a. Informent's Name/Relationship (Type, Print) 4636 Golden H: 11 Rd. Church CKeek, MD. 21622 Stanley Sie 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, Stata Date 20a. Method of Disposition 1 Burial 2 □ Cramation 3 □ Ramoval from State 7/24/99 Madison Cemetery 4 Donation 5 Other (Specify) WOOLFORD 21. Signatura of Funeral Service Licensee 22. Nama and Address of Facility HOME P.A. Henry Funeral 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death CARDIOPYLMONARY ARREST Immediate Cause (Finat disease or condition resulting in death) Due to (or as a consequence of): CARDIQC ARRYTHMIA Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or es a consequenca of) INFARCTION -Acute myocardial Dua to (or as a consequence of) 23b. Did tobacco usa contributs to the cause of death? 3 □ Probably 4 Wnknown 1 ☐ Yes 2 ☐ No HYPERTENTION -24b. Were autopsy findings available prior to 24a. Wes en eutopsy completion of cause of deeth? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 R/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No

siclan and burial-transi that the death certificate be execu Division of Vital Records, P.O. Box 68760, the 60 esn 500 page 2 has certificate Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica weby filled in by the funeral director, I

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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Examiner

Physician/Medical

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Certification:

Medical

**Funeral** 

Director

23a

b

'natural'

Hygiene.

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Department of Important: If

**Physician** 

/Medicai

Examiner

the Medical Examiner

Maryland 21215-0020

altimore,

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner?

1 to Yes 2 □ No

29e. Certifier (Check only one)

2 Accident 3 Suicida

4 Homicide

1 \*\*Certifying Phyalclan: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner es steted.
2 \*\*Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatura and titla of certifiar

31. Date filed (Month, Day, Year)

JUL 2 1 1999

29c. Licanse number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

+ mil. K. Matagan mD

6 Could not be determined

D50689

811999.

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

ANIL K. MAHADAN- PGHUSPITAL. EMFRGENCY DEPARTMENT CHEVERLY, MD 20785

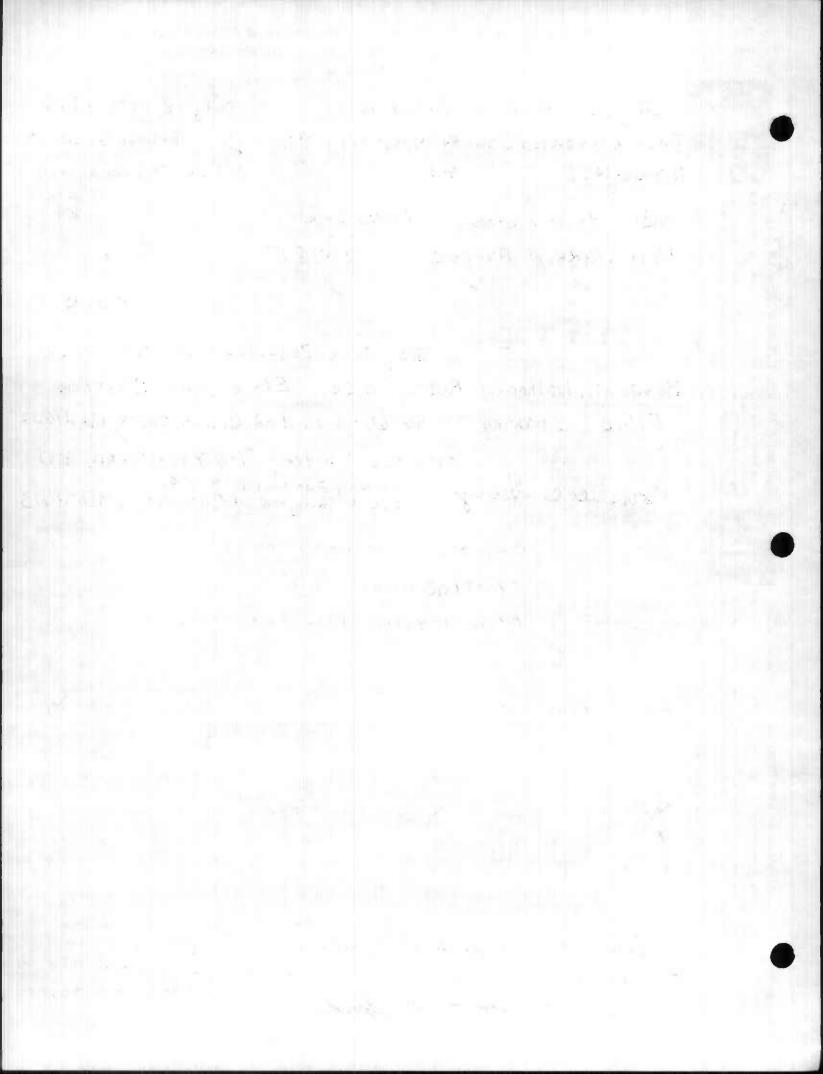
3001 HOSPITAL DRIVE.

State Registrar 32 Registrar's Signature

28e. Placa of Injury - At homa, farm, straat, factory, office building, etc. (Specify)

24 hours

To the Hosp within 24 ho To the Fune completely fi



State of Maryland / Department of Health and Mental Hygiene

2440

						Ce	rtificate	of	Death			Reg	. No.	lines (	
		1. Decedent's Neme (First, M	iddle, Last)								2. Date of		Day	Year	3. Tima of Death
	Physician /Madinal	Toribia G.	Rodri	guez							July			Year	2:05AM
1	· · /Medical Examiner	4a Facility Nama (If not instit			m <i>ber)</i>				4b. City, To	wn, or L	ocation of I		4c. County	of Death	
A		Manor Care-	-Fernw	boo					Beth	esda			Mont	gomer	V
	Funeral	5. Social Security Number	6. Sex		7. Age (In yrs.	last birthday,	If Under				6. Date of	of Birth		9. Birthp	lace (State or Foreign
L	Director	224-80-4885 Usual Residence of Deceden		м 2 <b>X</b> 1 F	8	2 Yrs.	Months	Days	Hours	Min.	April	17,	1917	Repu	flic of idad
	aryland	10a. State 10b. Cou	inty		10c. Ci	ty, Town or L	ocation							10	Od. Inside City Limits
	iter deeth with the Maryland r terms 23s or 28s-f show ites must be notified Funeral Director	N/A	N/A		Wa	shingt	on, De	C							Yes 2□No
	or 28	10e. Street and Number					10f. Zip	Code				100	. Citizen of	What Coun	try?
	ns 23a must b	3023 14th St.	. NW #	311			200	001				U	.S.A		
	items 23 ber must	11. Marital Status	1.	2. Was Dece Armed Fo	edent Evar in U	I,S. 13.	Was Decede	ent of H	lispanic Ori	igin? (Sp	ecify Yes o	r No-		e - Amaric	
0		1 Navar Marriad 2 I		1 Yas	24 No		1□Yes 2	-					Specif		
90	rest, o	3 X Widowed 4 □ Divor	ced	Year or D										рта	
21215-0020	led within 72 hours lygiena. To the medical Ent. Tr. to Medical Ent.	15. Deca (Specify only hi	dent's Educi ghest grada	ation completed)		16a. Dece (Give	dent's Usual kind of work DO NOT use	Occup done	ation during mos	st of work	king	16	b. Kind of B	usiness/inc	lustry
121	within ena.	Elementary/Secondary (0-1	2)	College (1	1-4or 5+)				a)			M	aintan		
	al Hygiena. I other than vent, the M	17. Father's Name (First, Mid	do ( ont)			nous	ekeepe	L	10 Moth	or's Nom	o /First 14		iden Suman		
and	De fi												luen Sumen	rra/	
Z	should be nd Mental marked o imatic eve	Eusibio Rodr				100 100	A MARKAGANA	(0)			ad Bor		24 T.	C4-4- 7:-	0-4-1
, Maryland	permit. Pages 1 and 2 should be filed within Department of Health end Mental Hygiena. Important: if item 27 is marked other than any injury or other traumatic event, the Mones.  To Be Comp	19a. Informant's Name/Relati					Newto								
Baltimore,	of He	20a. Method of Disposition				Place of Disponentery, cre	osition (Name	e of her pla	ce)		Date	20	c. Location	- City or To	wn, State
Ĕ	permit. Page Department of Important: If I any injury or page.	4 □ Donatton 5 □ Othe		movattrom		te of	Heaver	Ce	emeter	<b>:y</b>	7/24/	1999	Silv	ver Sp	oring, MD
alt	Department mportain injury inj	21. Signature of Funaral San	rice Ltcense	9			2. Nama and			,					
B	88 3 8	Thomas	3.	20	nulak	Lea N	oseph W, Was	Gav	ler's	SOI	2001	C, 5	130 W	iscons	sin Ave.
		23a. Part1. Entar tha disaase	, or complic	ations that o	aused the daar	th. Do not en	ter tha mode	of dyi	ng, such as	cardiac	or respirate	ory arres	t,		Approximate
8	Physician	23a. Part1. Entar tha disaase, or complications that caused the daath. Do not enter tha moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate the moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													Onset and Death
	/Medical	Immediate Ceuse (Final disease or condition Leukemia												1	
	Examiner	disease or condition resulting in death)  Due to (or as a consequence ot):													
	ficate be executed physician and st the bunel-transit edical Examiner	Sequentially tist conditions,  Due to (or as a consequence of):													
ó	ertificate be execut ling physician and ta as the bunel-trar Medical Exan	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events  Due to (or as a consequence of):  Hydronephrosis  Due to (or as a consequence of):													
68760,	nysic he bu	Couse (Disease or injury that initiated events resulting in deeth) Lest  Due to (or as a consequence of):													
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	v requires that the death cer been signed by the attendin should be detached for usa leted by Physician/N	Part It. Other significant con-	ditions cont	ributing to de	eath but not res	ulting In the	underlying ca	use gi	en in Part	1.	23b.	DId tob	acco use co	entribute to	the cause of death?
P.0	requires that the een signed by th hould be detache	Hypertensic	n Po	nol T	on ffin	ioner						1 🗆 Yes	2X No	3□ Prot	bably 4 ☐ Unknow
	es the grade of the d	hypertensit	m, ke	nar II	ISUITIC	Tency		_						_	
Records,	The lew require sate has been signate has been signated.											Was an performa		ava	ere autopsy findings ailable prior to
e C	has be													of	mpletion of cause death?
R	The la											1 🗆 Yas	2 <b>X</b> No	10	Yes 2□ No
Vital	certificate rector, pag	25. Was case referred to med	tical						26. Place	e of Dea	th (Check	only one			
of V	7 00	axaminer? 1 ☐ Yes 2 📉 No	Ho	ospital:	Inpatient 2	ER/Outpatle	nt 3 DO.	A Oth	ner: 4X N	ursing H	ome 5 🗆	Residen	ce 6 Ott	ner (Specifi	y)
0	g Ph lar th neral	27. Manner of Death  1 Natural 5 Pe	ndina	28a. Date	of Injury th, Day Year)	28b. Time o	of 28	Bc. Inju	ry at		28d. Desc	ribe how	tnjury occu	rred	
Division	ath. r: Aff be fur	2 ☐ Accident thv	estigetion	(	,,,	,,	М		Yes 2	No					
Vis	ar de recto by the by the	3 Suicide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify)									28f. Locat	ion (Stre	et and Num. State)	ber or Rura	l Routa Number,
Ö	tal or Attending P rs after death. al Director: After ti led in by the funera Certification:			Conta	ing, oto. (opoon	37									
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:			er: On the bi	best of my kno asts of axamina ner stated.										
	o the	29b. Signature and title of car	tifier	<i>( (</i>	- Allegaria		29c.	Licens	sa number	-		290	d. Date signe	ed (Month,	Day, Year)
	1/	> Kist	1. 1	10hr	a h	1.1	D	202	74			Jı	uly 13	, 199	9
	4	30 Name and address of an	on who are	noleted co.	o of doath /it-	n 23el /T	Print\								
		30. Name and address of pers						hac	da M	m 24	1017				
	State	Kirti Voh 31. Date filed (Month, Day, Yo			legistrar's Stgni		-			W 2(	OTI				
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death July **Physician** 9 Ann L. Reuther 7:00pm/Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Nursing Home Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Deys 1 M 2 F Months Hours 82 233-03-1895 1/2/1917 Director Ohio Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28s-f show 1 Yes 2 No Director Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 43 W. McKinsey Rd. USA Nema 23a 21146 filed within 72 hours after death Hygiene. Wher than "natural", or Nerma 23 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Meritel Status Black, White, etc. 1 ☐ Yes 2 No 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1□ Yes 2□ No Specify py 3 Widowed 4 Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: if item 27 is marked other than any injury or other traumatic event, Ital. DRGs. Homemaker Home 17. Father's Name (First, Middle, Last) 18 Mother's Neme (First Middle Meiden Sumame) Be William E. Ackermann, Sr. Louise Fehrenbach 19s. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Edward E. Reuther 43 W. McKinsey Rd. Severna Park MD 21146 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method ol Disposition 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removel Irom Stete
4 Donetion 5 Other (Specify) MD Veterans Cemetery 7/12 Crownsville, 22. Name end Address of Facility
Barranco & Sons, P.A. Severna Park F.
495 Ritchie Hwy Severna Park MD 21146 21. Signature of Junioual Service Licenses P.A. Severna Park F.H. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, bock, or heart leiture. List only one cause on each line. Approximate Intervat Between Onset and Deeth **Physician** /Medical tmmediete Ceuse (Fine) Lyslans disease or condition resulting in deeth) Examiner Examiner ician and burial-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of): physician a Box 68760. Physician/Medical Due to (or as a consequence of): 980 signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 3 Probably 4 Unknown 1 Yes 2 No Division of Vital Records. ģ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an eutopsy performed? 200 No 1 ☐ Yes 2 No 1 ☐ Yes or Attending Physician: 25. Was case relerred to medical axaminer? Be 26. Place of Deeth (Check only one) Other: Nursing Homa 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Menner of Deeth 28d. Describe how injury occurred 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? After 1 Accident 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. investigation 6 Could not be determined 3 ☐ Suicide 281. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece ol Injury - At home, lerm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. (Check only one) To the F within 2 29b. Signeture end titte of certifie 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of deeth (ttem 23a) (Type, Print) "Blod suite 101 Croften mo 21114 and 16 Crotton 2 31. Dete liled (Month, Day, 32. Registrer's Signeture State Registrar

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State of Maryland / Department of Health and Mental Hygiene

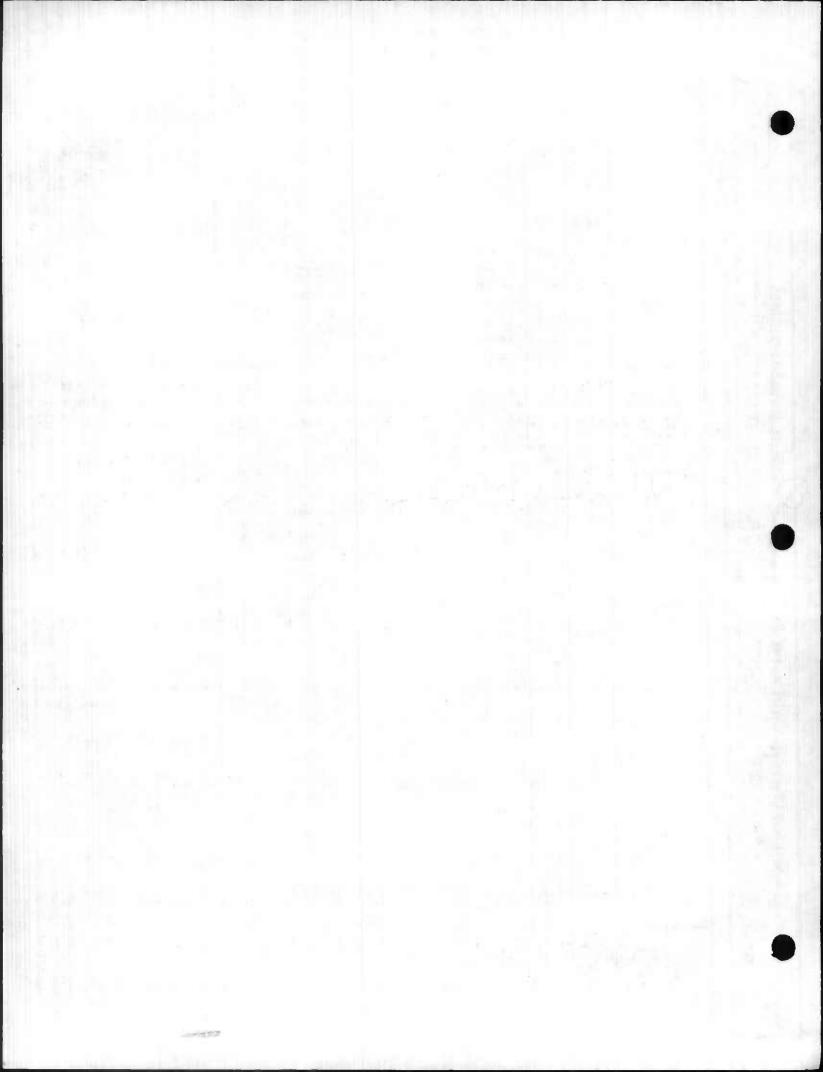
AMEND# 16A 7/14/99 AACO HEALTH CMH Certificate of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death 2. Date of Deeth Month **Physician** 12:15 AM July 12 1999 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
California 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1₩ 2□ F Yrs May 9, 569-01-2165 78 Director Usual Residence of Decedent with the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Itsm 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic avent, the Medical Experies must be notified at X¹□Yes 2□No Directo Maryland | Anne Arundel Annapolis 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21401 1611 Harmony Acres Lane USA Funeral death 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiena. Important: if item 27 is marked other than "natural", or item any injury or other traumatic avent, the Healtgal Exercised once. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
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AIHLETILE 16h Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Sports Medical Athleic Trainer 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Juan Romo Margaret 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 329 Locust Ave. Annapolis, MD 21401 James Romo (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition t☐ Surial 2 ☐ Cremation 3 ☐ Removel from Stete
4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Cemetery 7/15/99 Annapolis, MD 22. Name and Address of Facility 21. Signature of Funeral Septice Lice John M. Taylor Funeral Home recon 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Fartf. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List party one cause on each line. Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 3 months MALNUTRITION Examiner Due to (or as a consequenca of): Examiner CEREROVASCULAR ACCIDENT physician and s the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): the death certificate be exec P.O. Box 68760 Physician/Medical Due to (or as e consequence of): 88 98n 23b. Did tobacco use contribute to the cause of death? Part II. Other eigniffcant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION, DEMENTIA à Division of Vital Records. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificata has 1 Yes 2 1 No 1 TYes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 LHO 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how Injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 5 Pending investigation 1 [[Netural 1 Yes 2 No 24 hours after death. Funeral Director: Af 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner as stated. edical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the P 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Island Rol, MARGES TO old Solomon's STEPHEN J KATZI m.O 139 31. Date filed (Month, Day, Year) 32/Registrar's Signature State JUL 1 4 1999 Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Year Month **Physician** 21, Angelo Ripoli July 1999 12:05 PM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number Birthplaca (State or Foreign Country) 7. Aga (In yrs. last birthday) **Funeral** Days Months 1₺ M 2□ F 91 Sept. 20,1907 Pennsylvania Director 177-10-8638 Usual Rasidance of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1K Yas 2 No Director Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Nome 23a 101 Odendhal Avenue, # 712 20877 United States Funeral death 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mentel Hygiens. Introcrams if it is not 71 is marked other than "natural; or its man injury or other traumatic event, pre Medical Emerical 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 1 Nevar Married 2K Warrled Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) 8 Foreman Chair Factory 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Be Nicholas Ripoli Μ. Philomena Buccarato 19a. tnformant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Evelyn J. Ripoli/Wife 101 Odendhal Ave., # 712, Gaithersburg, MD. 20877 20b. Place of Disposition (Name of cematary, cremetory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☑ Burlal 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) 7/24/99 Lock Haven, PA. Agnes Cemetery St. 22. Nama and Addrass of Facility of Funeral Service Licenses DeVol Funeral Home 10 E.Deer Park Dr., Gaithersburg, MD. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intarval Between Onset and Death **Physician** /Medical tmmediate Causa (Final disaasa or condition rasulting in death) Examiner Examiner The law requires that the death certificate be executed physician end s the burial-transit Sequentially list conditions, if any, laading to immadiata cause. Entar Undarlying Cause (Disease or Injury that initiated events rasulting in deeth) Last Box 68760. Seiz Physician/Medical Dua to (or as a consequence of): P.O. Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? been signed by t should be detach 1 Yes 2 No 3 Probably 4 類Unknown Records, by 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24e. Was an autopsy performed? 1 ☐ Yas 2 ZNo 1 ☐ Yas 2 € No Division of Vital or Attending Physician: Be 25. Was case rafarred to medical axaminar? 26. Placa of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Rasidence 8 Othar (Specify) 5 1 Yas 2 No 2 ER/Outpatient 3 DOA 1 Linpatiant this 27. Menner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Medical Certification: Affer 1 Matural 5 Pending invastigation 1 ☐ Yas 2 ☐ No 24 hours after death.

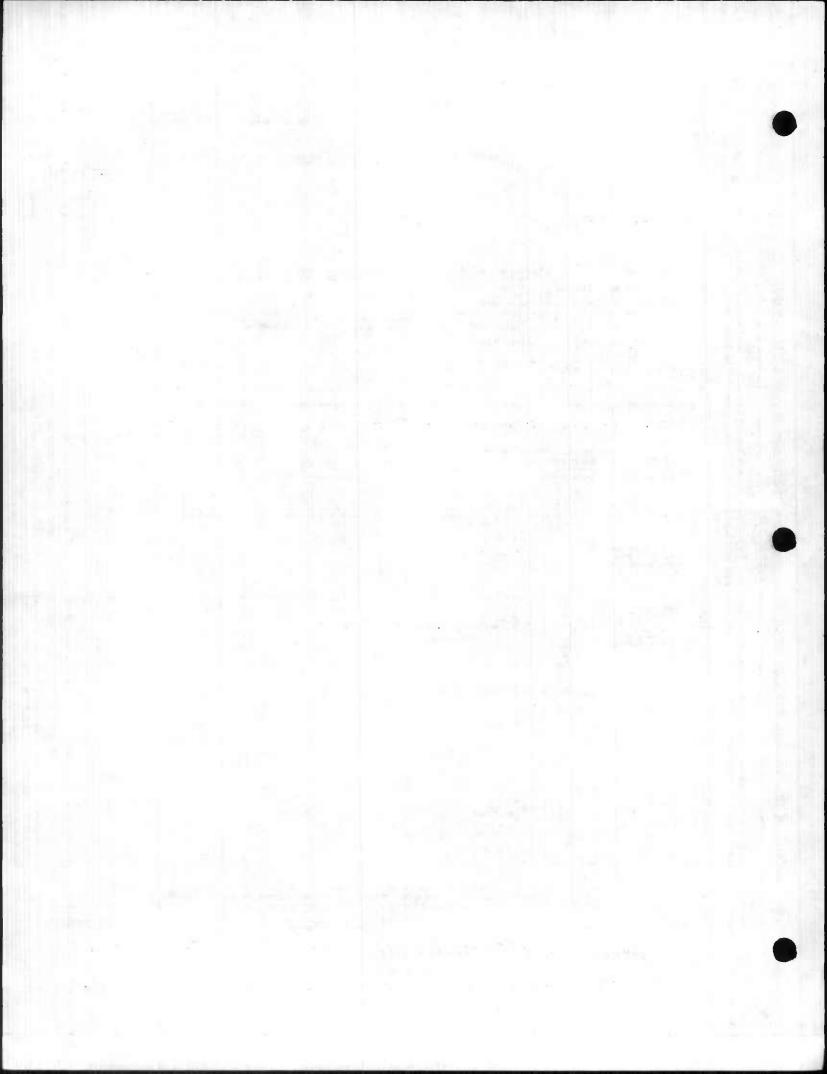
Funeral Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Routa Number, City or Town, Stele) 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida filled in Hospital 29a. Certifiar 1 Cortifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) end mannar as stated. To the Fune completely f (Check only one) 2 Medicat Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 To the 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signatura and this of corple 735792 JULY, 21, 1999 30. Nama and address of pareon complated cause of death (Item 23a) (Type, Print) SWARDOP. W. EDMONSTON DR, ROCKVILLE, MD 50 32. Registrar's Signatura 31. Data filed (Month, Day, Year State Registrar 2 2 1999



State of Maryland / Department of Health and Mental Hygiene 99

99 24405

			C	ertificate	of L	Death			Reg. No.			
	1. Decedent's Name (First, Middle,	Last)						2. Date of De		V	3. Time of D	leath
Physician	Joseph	С.	Rogers					July 1	L9, 19	99	5:00	AM
/Medical Examiner	4a Facility Name (If not institution,		U		4	b. City, To	wn, or L	ocation of Deat		inty of Death		
Examiner	13622 Autumn Tra	ail Drive			(	Germa	ntow	m	Mon	tgomer	v	
Funeral	5. Social Security Number	S. Sex 7. Age	(In yrs. last birthda	y) If Under 1 Y	ear	If Under	24 Hrs.	8. Date of Bir	th		place (State or intry)	Foreign
Director	141-30-8165	1₩ 2□F	60 Yrs.	Months D	ays	Hours	Min.	May 4,	1939	Penr	ntry) nsylvan:	ia
	Usuat Residence of Decedent										J	
within 72 hours after death with the Maryland ene. The "reture!", or heme 28e or 28e-f ehow the heades! Exemples must be notified at the modeled by Funeral Director	10s. State 10b. County		10c. City, Town or	Location							10d. Inside City	Limits
Man o	New Jersey Camden	n	Cherry I	4111							1 ☐ Yes 2	2 💢 No
or 28-4 be notified	10e. Street and Number			10f. Zip Co	de				10g. Citizen	of What Cou	ntry?	
4 0				0000	0.0							
r tems 23s or 28s-t show	11. Marital Status	12. Was Decedent E	iver in H.S. 11	0800 3. Was Decedent		enania Ori	inin? /Sn	point Ves or No		d Stat		-
E	11. Martai Status	Armed Forces?		If Yes, specify	Cubai	n, Mexicar	, Puerto	Rican, etc.)		Black, White,		
9 = -		If Yes, Give	ю	1 ☐ Yes 2 ☑	No	Specify:			Spe	ecity: Wh	ite	
"naturel", edical Ex-	3 D WILLIAM 4 ZI DWILLOW	Year or Dates:	1 10 0	1 1 1 10		**			400 40 4			
Completed	15. Decedent's (Specify only highest		(Gi	pedent's Usual O we kind of work of	lone d	luring mos	t of work	ing	160. Kind (	of Business/Ir	noustry	
then the	Elementary/Secondary (0-12)	College (1-4or 5	+)	. DO NOT use n								
Se Co	12			Carpent	ter					Emp1c	yed	
To Be	17. Father's Name (First, Middle, Li	ist)				18. Mothe	er's Nam	e (First, Middle	, Maiden Sur	name)		
To To	Joseph F. Rogers					Catl	neri	ne C. L	eonard			
	19a. Informant's Name/Relationshi	p (Type, Print)	19b. Ma	iling Address (S	treet a	and Numbe	er or Rur	ral Route Numb	er, City or To	wn, State, Zi	ip Code)	
other treu	Maureen Linstrom	(daughter)	1362	2 Autum	n T	rail	Dri	ve, Ger	mantow	n, MD	20874	
e de	20a. Method of Disposition		20b. Place of Dis		of			Date		on - City or T	own, State	
eny injury or once.	1 Burial 2 Cremation 3 4 Donation 5 Other (Spe		Chesape				1 -	7-22-99	Relter	71110	Maryla	nd
2 7	21. Signature of Funeral Service Li	**	Onesape	22. Name and A				22 ))	DCICO	V 111C 9	mar y ra	IIG
900				The Step	phe	nson-	Brow					
	Larol	L Llekn		33 W Map	ole	Aver	nue,	Mercha	ntvill	e, NJ	08109	
	23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caused by one cause on each lin	the death. Do not e	enter the mode of	f dying	g, such as	cardiac	or respiratory a	rrest,		Approximate Interval Between	een
cian											Onset and De	ath
ical	Immediate Cause (Final disease or condition	PNEUMON	[A									
ner	resulting in death)	a	Due to (or as a cons	sequence of):								
ě			RROW APLA									
Examiner	Sequentially list conditions	b	Due to (or as a cons	sequence of):								
×	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ACTITE MY	EOLOGENO	IC I FIIVE	'MT					i		
edical	Cause (Disease or injury that initiated events	C	Due to (or as a cons		4114	FA.				-		-
9	resulting in death) Last		,									
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etached for us Physician	Dart II Other elevificant condition	a anatributina ta daeth hu	d and annulting in the	undark dan anua	o obs	on in Dard I	1	225 Did	tobacco use	contribute	to the cause of	double
ohe iche	Part II. Other significant condition	s continuoung to death bu	n not resuming in the	underlying caus	a give	en wirani	١.					
detached for								םי ו	Yee ak	lo 3∏Pro	DOBBBY 4 U	Inknow
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rector.	25. Was case referred to medical					26. Place	of Deal	th (Check only	one)			
i director, pay To Be Co	examiner?	Hospital: 1 ☐ Inpatie	nt 2 ER/Outpat	ient 3 DOA	Othe	er: 4 Nu	ursing Ho	ome 5 Resi	dence 6 🙀	daught Other (Spec	er's Freside	on Ce
	27. Manner of Death	28a. Date of Injur (Month, Day	y 28b. Time	of 28c.	tnjury	at		28d. Describe				
• fune	1 Natural 5 Pending 2 Accident investiga		Year) Injury	м		Yes 2□	No					
in by the	3 Suicide 6 Could no	t be 28e. Place of Inju	ry - At home, farm,	street, factory, of	ffice		1			umber or Ru	ral Route Numb	er,
<u> </u>	4 Homicide	building, etc	(Specify)				- 1	City or To	wn, State)			
§ 2	29a, Certifier 1X Certifying	Physician: To the best o	I my knowledge de	ath accurred at ti	ha tim	o data as	nd place	and due to the	course(s) on	I manner ac	etated	
completely filled Medical Ce		aminer: On the basis of and manner sta	examination and/or									
completely filled i	29b. Signature and title of certifier	and manner star	180.	29c 1 i	iconee	number			20d Date si	gned (Month	Day Year	_
8 -	250. Signature and title of Certiner	DC-1	111.			10.11						
	Geralden	E PSUE	cher,	UD DO	:11:	241		•	JULY 2	1, 199	9	
>	30. Name and address of person wi	no completed cause of de	eath (Item 23a) (Typ	e, Print)								
	GERALDINE P. SCI	HECHTER, M.I	VAMC,	50 IRVI	NG	STRE	ET N	W, WASI	HINGTO	N, DC	20422	
State	31. Date filed (Month, Day, Year)	32. Begistre	r's Signature									
Registrar	JUL 22 19	99 Afres	· B.	popou	6							

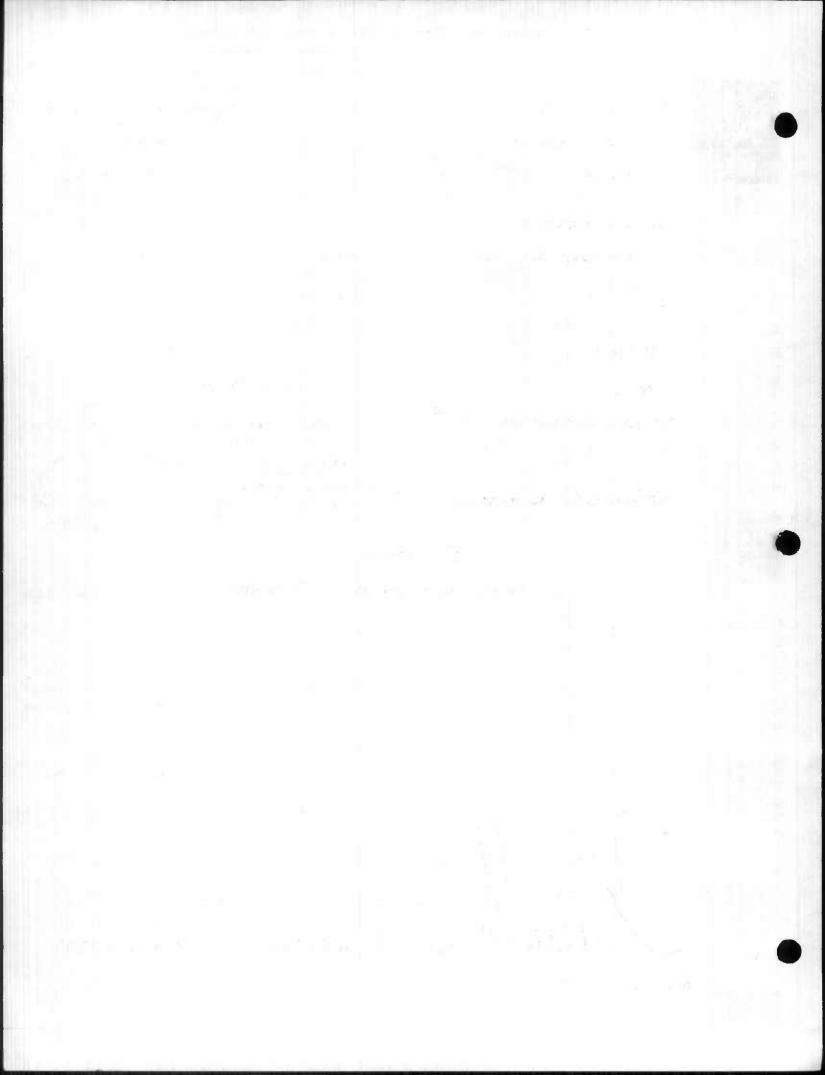


State of Maryland / Department of Health and Mental Hygiene

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7			Manorcare -	Potomac					Potom	ac		М	ontgo	merv	
т	Funerai		5. Social Security Number	6. Sax	7. Aga (In yrs. I	ast birthday	If Undar 1		If Undar 24	4 Hrs.	8. Data of Bir	th	9. Bi	rthpisca (5	Stata or Foraign
	Director		577-54-0114 Usual Rasidance of Dacadant	1□M 2□F	8	8 Yrs.	Months [	Days	Hours	Min.	(Month, De March			ountry) Maryl	and
	filed within 72 hours efter deeth with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ont, the Modical Examiner must be notified at		10e. Stata 10b. County	/	10c. City	, Town or L	ocation							10d. Ins	ide City Limits
	Maria Maria	to	Maryland Mor	ntgomery	Do	tomac								10	Yas 2□No
	1 the	Director	10e. Straat and Number	regomery	FO	LUIIIAC	10f. Zip C	ode				10g. Citiza	n of What C	ountry?	
	3a o	0	10714 Potoma	a Monnia	Tano		20	854	ı			TT.	CA		
	deett 78 2	lera	11. Maritai Status	12. Was Dac	edant Evar in U.	S. 13.				n? (Spe	cify Yas or No		S. A.	and the same of th	lan.
0	ther characteristics	Funeral	1 ☐ Navar Married 2 ☐ Mar	Armed For	2 □ No		If Yas, specify	Cuba	n, Maxicen,	Puarto I	cify Yas or No Rican, atc.)		Black, Wh		,
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Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Signatura of Funeral Sarvice			2:	2. Nama and	Addras	ss of Facility	nera	l Dire	ction			
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	n 24 n 24 ne Fi	edicai	one) Medical	Examinar: On the bi	asis of axaminati ner stated.	ion end/or/in	vestigetion, in	my of	oinlon, deeth	occurra	d at the time,	dete end pl	ece, end du	a to the ca	iuse(e)
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<b>Funeral Director</b>	Md 10e Stree	et and Number	ontgon	nery	Ke	ensin		Zip Code			10g. Citizen of \	What Country		
5			Dood					208			U.S.A			
101	11. Marita	Saul Status	Road	12. Was Dace	dant Ever in	U,S. 1	3. Was Dec	edant of	Hispanic Origin? (	Specify Yes or No	- 14. Rac	e - American		
	1 N	avar Married	2 Marriad	Armed Fo	2 No			20 No	ben, Maxican, Pue Specify:	no moan, etc.)	Specifi	ck, Whita, at v: <b>whi</b>		
d by	3 <b>X</b> W	/idowed 4 🗆	Divorced	Year or D			1 1 1 00	230 11	э оросну.					
Completed			Decedant's Ed	ducation ada complated)		16a. De	iva kind of	vork don	upation a during most of w pod) Direct	orking - F	16b. Kind of B		Counsel	
дшс	Eiamen	tery/Secondar	y (0-12)	Collega (1	-4or 5+)	Over	six	tv	employm	ent Svo		-	nt Svcs.	
0	17. Fatha	r's Nama (First	, Middla, Last,			0 4 6 1		-1	18. Mothar's No	ema (First, Middle	, Maiden Suman	na)		
To B	Will	Liam A	. Mil	ler					Luce	tta Car	by			
-		mant's Name/				19b. M	eiling Addre	ss (Strai	at and Number or F		-	, Stata, Zip C	Coda)	
	Kenr	neth S	. Spr	inkle	- Son	880	00 Hi	dde	n Hill	Lane Po	tomac,	Md.2	20854	
		od of Dispositi		Removal from		Piaca of Di cematary,	sposition (h cramatory o	lama of r othar pi	lace)	Data	20c. Location -	- City or Tow	n, Stata	
	1 Surial 2 Cramation 3 Removal from Stata 4 Donation 5 Other (Specify)  Rosedale Cemetery 7/19/99Martinsburg, WVA  21 Signature of Funeral Service Licensee													
Suce.	21. Signatura of Funarai Sarvice Licansea  22. Nama and Addrass of Fecility  Joseph Gawler's Sons  Thomas E. Hornbaker  5130 Wi. Ave. NW. Washington, DC. 2001													
a		Thom	as E	. Home	laker				Ave. N	W. Wash	nington			
	23a. Pari sho	t1. Entar tha di ck, or heart fail	saasa, or com lura. List only	plications that o one causa on e	aused the dat ach line.	ath. Do not	antar tha m	oda of dy	ylng, such es cardi	ac or raspiratory a	rrast,	, 1	Approximete ntarval Between Onsat and Deeth	
	Immediat	a Ceusa (Fine										1	onsat and Deeth	
		or condition		a. Ca					ystole	)				
Jer				2		(or as a con			1	ilam Di	20222			
Examiner	Sequentin	ally list condition	ons.	b. Atl		:Lero			diovascu	Har D1	sease			
EX	if any, las causa. E	ally list condition ding to immadintar UndarlyIng	liata		/-									
dical	thet initie	isease or injur ted avants in death) Last	5	C	Dua to	or as a con	sequanca o	f):				1		
0		,	L	d								i		
by Physician/M				ų.										
ysk	Part II. Oti	her significant	t conditions c	ontributing to de	ath but not ra	sulting in th	a undarlyin	causa g	jivan in Part I.				he cause of death?	
Z	Dia	betes								10	Yes 2□No	3 Proba	bly 40 Unknow	
ם ס											en eutopsy	24b. Wer	e eutopsy findings	
Completed										perfe	ormed?	com	labla prior to pletion of cause seth?	
5										10	Yas 2 No		Yas 2□ No	
0		case refarred to	o medical					-	28. Placa of D	eath (Check only				
To B	exa <i>m</i> i 1 □ Y	nar? as 2 No		Hospital:	npatient 2	ER/Outpa	tient 3	DOA C	ther	Homa 5□Res		her (Specify)		
	27. Manne	er of Death	☐ Panding		of Injury th, Dey Year)	28b. Tim	a of	28c. fnj W	-		how Injury occur			
Certification:	2 🗆 A	ccident	Invastigation	n	,,	,0	M		☐ Yas 2 ☐ No					
THE		uicida 6 l łomicida	Could not b datarminad	26a. Place	of Injury - At ng, atc. (Spec	homa, farm cify)	streat, faci	ory, office	0	28f. Location ( City or To	(Streat and Numi wn, Steta)	ber or Rural i	Routa Number,	
edical	29a. Cart (Che	ck only 2		niner: On tha be	asis of axamir				time, dete and place opinion, daath occ					
	U UVIE	,		anu men	ner stated.									

29a. Cartifiar (Check only one) 167 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and menner stated. 29d. Date signed (Month, Dey, Year) 29b. Signature end titla of cartifian

29c. Licansa number

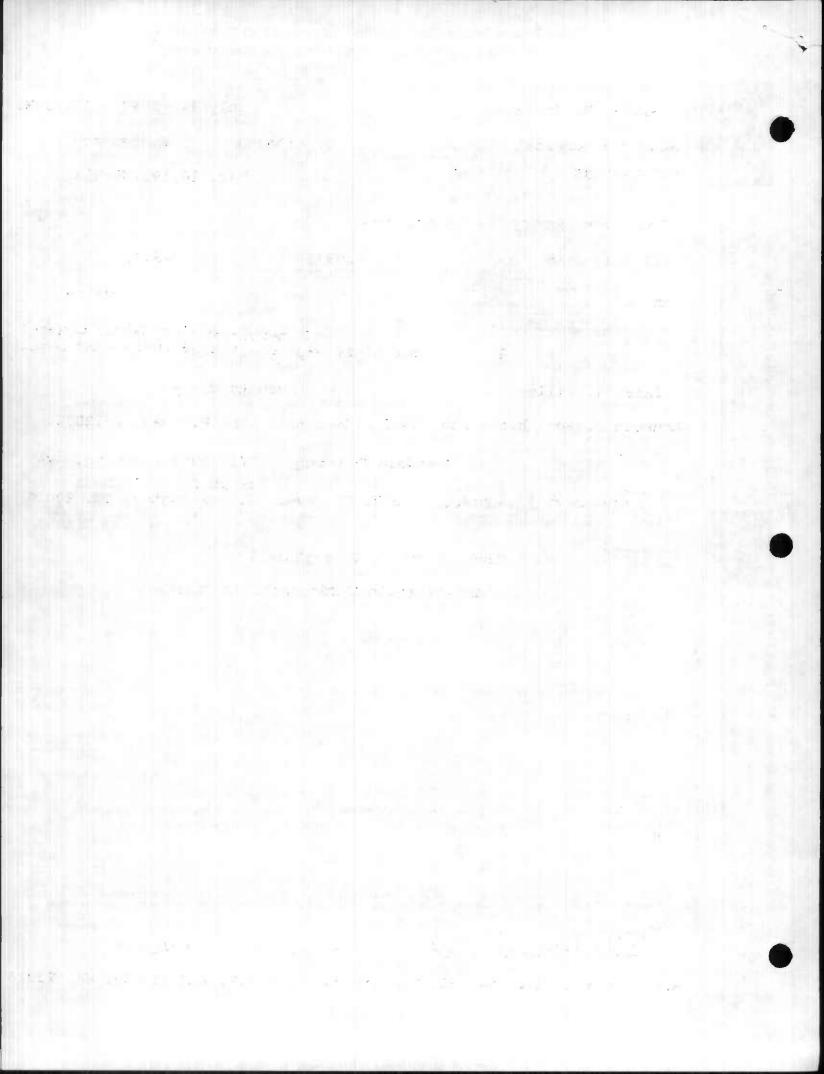
07/16/99

30. Neme and address of person who completed causa of death (Itam 23a) (Type, Print)

8600 Old Georgetown Rd. (E.R.) Berhesda, Md. 20814 B.W. Leonard,

D54776

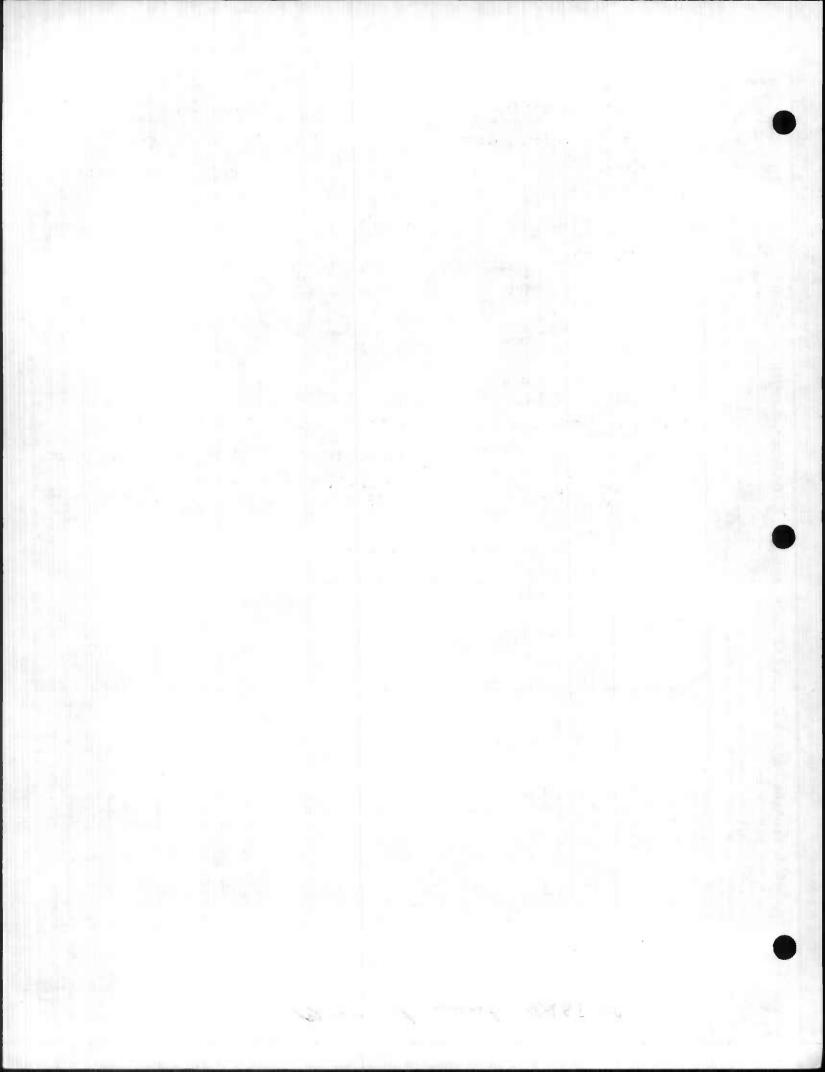
State Registrar 31. Data filed (Month, Day, Year) 32. Registrar's Signatura souls 2 3 1999



State of Maryland / Department of Health and Mental Hygiene 99 24408

				Ce	imeate	OI L	eath			Reg. No.				
ysician	Decedent's Name (First, Midd	le, Last)							2. Date of Dea Month	ath Day	Year	3. Tima of Death		
ysician Medical	Frances G.	. Sterling							July			8:45 A.M		
aminer	4a Facility Name (If not institution	n, give street and nu	mber)			4t	. City, Tov	vn, or Loc	ation of Death	4c. Count	of Death			
	Anne Arundel M	Medical Ce	enter				Annar	olis		An	ne Ar	undel		
eral	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 \	/ear	If Under 2	4 Hrs.	8. Date of Birt (Month, Day	h Voer)	9. Birthr	lace (State or Foreig		
ctor	215-24-1552	1□ M <b>X</b> (X)F	70	Yrs.	Months	ays	Hours	NIII.	ov. 27	. 1928	Tenn	essee		
	Usual Residence of Decedent													
э.	10a. Stale 10b. County	1	10c. Cit	y, Town or L	ocation						1	0d. Inside City Limits		
be notified at Director	Maryland Anne	Arundel		Annar	olis							1 ☐ Yes 2 🗖 No		
Directo	10e. Street and Number				10f. Zip Co	ode				10g. Citizen of	What Cou	itry?		
	3 Spruce Lane				2	140	1			US	A			
Funeral	11. Marital Status	12. Was Dec	edent Ever in U	S. 13.	Was Deceden	t of His	spanic Orig	in? (Spec	cify Yes or No-		e - Americ			
2	1 Never Merried 2 Mer		2 X No					, Pueno F	tican, etc.)		ck, White,	atc.		
by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Gi	ve lates:		1□Yes 2)	N/NO	Specify:			Specif	Whi	te		
Completed	15. Deceder	nt's Education		16a. Dece	dent's Usual O	ccupa	tion		- T X T	16b. Kind of B	usiness/In	dustry		
ed.	(Specify only higher Elementary/Secondary (0-12)	st grade completed) College (		life.	kind of work of DO NOT use r	tone di retired)	uring most	of workin	9					
E	11th	College (	1~401 54)	Home	emaker					Hom	е			
Be C	17. Father's Name (First, Middle,	Last)					18. Mothe	r's Neme	(First, Middle,	Maiden Sumer	ne)			
0	Willia	am Forbes						Mar	tha G.	Arrowo	od			
-	19a. Informant's Name/Retations	ship (Type, Print)		19b. Maili	ng Address (S	treet e	nd Numbe	r or Rural	Route Numbe	er, City or Town	State Zir	Code)		
			1 . 1											
ŀ	Charles J. Ster	riing/ Hus	20b. F	lace of Disp	oruce Li	ane	Anna	DOTI	S, Mar	yland 2	- City or To	wn. State		
	1XXBurial 2 ☐ Cremation	3 Removal from	State	emetery, cre	metory or othe	r plece		5						
	4 Donation 5 Other (S		nı		st Ceme		-	t	21-99		IIS,	Maryland		
	21. Signature of Foreral Service Licensee  22. Name and Address of Facility George P. Kalas Funeral Home 2073 Selement Teland Rd. Education MD 21027													
	2973 Solomons Island Rd. Edgewater, MD 21037													
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between													
	Onset end Deeth													
	tmmediate Cause (Final disease or condition	Ca	rdiopul	monary	Arres	t					1			
	resulting in death)	a	-	ras a conse										
Examiner		Ac	lvanced			arc	inoma	ì						
	Constant to the second	b. ——		r as a conse							- 1			
3	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	,	000 10 (0	. 40 4 00/100	4001100 017.									
Ö	Cause (Disease or Injury that initiated events	c	Due to (o	as a consec	mence off:									
ROIDA	resulting in death) Last		0001010	as a conse	porioa ory.									
Ž		d												
	D										. 10			
Physician	Part It. Other significant condition	ons contributing to a	eath but not res	uiting in the u	nderrying caus	e give	n in Part I.					the cause of death		
									10	Yss 2□ No	3 🗌 Pro	bably 4/D/Unknow		
ğ			_						040 18400		24b W	ere sutopsy findings		
									perfo	an autopsy med?	av	ailabla prior to mpletion of cause		
											of	death?		
												Yes 2□ No		
Sendino		_							101	res 2 No	11	1 163 2 160		
	25. Was case referred to medica	1					26. Place	of Death	(Check only o		11	1163 20160		
Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpetient 2 🗆	ER/Outpatie	nt 3 DOA	Othe	er		(Check only o					
	examiner? 1 Yes 2 No  27. Manner of Deeth	Hospital:		28b. Time o			<sup>C</sup> 4□ Nu	rsing Hom	(Check only one 5 Resid	ne)	ner (Specia			
To Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1X	Inpetient 2 Do thjury th, Day Year)			tnjury Work	<sup>C</sup> 4□ Nu	rsing Hom	(Check only one 5 Resid	ne) denca 6 □Ott	ner (Specia			
To Be	examiner?  1 Yes 2 No  27. Menner of Deeth  1 Netural 5 Pendir  2 Accident investi  3 Suicide 6 Could	Hospital: 128a. Date (Mon getion not be land) 28e. Place	of tnjury th, Day Year)	28b. Time of tnjury	M 28c.	tnjury Work 1   Y	<sup>C</sup> 4□ Nul at ?	rsing Hom	(Check only one 5 Resided Rescribed	ne)  denca 6 □Ottl now injury occu	ner (Special			
To Be	examiner?  1 Yes 2 No  27. Manner of Deeth  1 Netural 5 Pendir  2 Accident investi  3 Suicide 6 Could	Hospital: 128a. Date (Mon getion not be land) 28e. Place	of tnjury th, Day Year)	28b. Time of tnjury	M 28c.	tnjury Work 1   Y	<sup>C</sup> 4□ Nul at ?	rsing Hom	(Check only one 5 Resided Rescribed	ne)  denca 6 □Ottl now injury occu	ner (Special	y)		
Certification: To Be	examiner?  1 Yes 2 No  27. Menner of Deeth  1 Netural 5 Pendir  2 Accident investi  3 Suicide 6 Could  4 Homlcide	Hospital: 123a. Date (Mon getion not be nined) 28e. Place build	of tnjury th, Day Year) o of Injury - At ho ing, etc. (Specif	28b. Time of this this control of the control of th	M 28c.	tnjury Work 1 TY	at ? Yes 2 P	rsing Hom 2 No 2	(Check only one 5 Resided Resi	denca 6 Ottl now injury occu Street and Num	ner (Special rred ber or Rura	y) al Route Number,		
Certification: To Be	examiner?  1 Yes 2 No  27. Manner of Deeth 1 Netural 5 Pendir 2 Accident investi 3 Suicide 6 Could determ  4 Homlcide  29a. Cartifier 1 Certifylir	Hospital: 128a. Date (Mon not be nined 28e. Place build ng Physician: To the Examiner: On the b	of Injury th, Day Year)  of Injury - At he ing, etc. (Specifi	28b. Time of this this this this this this this this	M 28c. M reet, factory, of	tnjury Work 1   Y	at ? 'es 2 l	rsing Hom 2 No 2	(Check only of the 5 Resident	denca 6 Otto  denca 6 Otto  dence for injury occu  Street and Num  m, Stete)	ner (Special rred ber or Run anner as s	y) of Route Number,		
To Be	examiner?  1 Yes 2 No  27. Manner of Deeth  1 Netural 5 Pendir  2 Accident investi  3 Suicide 6 Could  4 Homicide  29a. Cartifier (Check only 2 Medicat	Hospital: 128a. Date (Mongetion not be nined 28e. Place build ng Physician: To the Examiner: On the band man	of Injury th, Day Year) of Injury - At h ing, etc. (Specifi best of my kno asis of examina	28b. Time of this this this this this this this this	M 28c.  M reet, factory, of a cocurred at the vestigation, in	tnjury Work 1 Y	at ? 'es 2 l	rsing Hom 2 No 2	(Check only one 5 Resident St. Describe 1)  8f. Location (City or You and due to the dat the time,	denca 6 Otto  denca 6 Otto  dence for injury occu  Street and Num  m, Stete)	her (Special rred ber or Run anner as s	of Route Number, tated. the ceuse(s)		
edical Certification: 10 be	examiner?  1 Yes 2 No  27. Manner of Deeth  1 Netural 5 Pendir  2 Accident investi  3 Suicide 6 Could  4 Homlcide  29a. Cartifier (Check only one)	Hospital: 128a. Date (Mongetion not be nined 28e. Place build ng Physician: To the Examiner: On the band man	of Injury th, Day Year) of Injury - At h ing, etc. (Specifi best of my kno asis of examina	28b. Time of this this this this this this this this	M 28c.  M reet, factory, of a cocurred at the vestigation, in	tnjury Work 1 Y	at ? es 2 l f	rsing Hom 2 No 2	(Check only one 5 Resident St. Describe 1)  8f. Location (City or You and due to the dat the time,	Ane) denca 6 Ott now injury occu  Street and Num m, Stete)  cause(s) and m dete and place, 29d. Date signe	ner (Special rred ber or Rum anner as s and due to	tated.  Day, Year)		
edical Certification: To Be	examiner?  1 Yes 2 No  27. Manner of Deeth 1 Netural 5 Pendir 2 Accident 3 Suicide 6 Could 4 Homicide  29a. Cartifier (Check only one)  29b. Signeture and title at certifier	Hospital: 128a. Date (Mon not be nined 28e. Place build ng Physician: To the Examiner: On the band man	of Injury th, Day Year)  of Injury - At he ing, etc. (Specify the sis of my known asis of examinal ner stated.	28b. Time of thirty owne, farm, st v) wledge, deat tion and/or in	meet, factory, of hoccurred at the vestigation, in 29c. Li	tnjury Work 1 Y	at ? es 2 l f	rsing Hom 2 No 2	(Check only one 5 Resident St. Describe 1)  8f. Location (City or You and due to the dat the time,	Ane) denca 6 Ott now injury occu  Street and Num m, Stete)  cause(s) and m dete and place, 29d. Date signe	her (Special rred ber or Run anner as s	tated.  Day, Year)		
edical Certification: To Be	examiner?  1 Yes 2 No  27. Menner of Deeth 1 Netural 5 Pendir 2 Accident 3 Suicide 6 Could determ  29a. Cartifier (Check only one)  29b. Signeture and title of certifying (Check only one)  30. Name and address of person	Hospital: 28a. Date (Mon getion not be and man getion not be 28e. Place build not physician: To the Examiner: On the band man who completed cause	of Injury th, Day Year)  of Injury - At he hing, etc. (Specification of the state o	28b. Time of thijury  orne, farm, st  //  wledge, deat tion and/or in	moccurred at the vestigation, in 29c. Li	tnjury Work 1 T	at ? e, date and inion, deat	No 2 d place, e h occurre	(Check only one 5 Reside 8d. Describe 1 St. Location (San Crity or Tay)  and due to the dat the time,	Ane)  Jenca 6 Ott  Street and Num  m, Stete)  Cause(s) and m  dete and place,  29d. Date signe	ner (Special rred ber or Rum anner as s and due to	tated.  Day, Year)		
edical Certification: To Be	examiner?  1 Yes 2 No  27. Manner of Deeth 1 Netural 5 Pendir 2 Accident 3 Suicide 6 Could 4 Homicide  29a. Cartifier (Check only one)  29b. Signeture and title at certifier	Hospital: 122 28a. Date (Mon pull) 28e. Place build ag Physician: To the Examiner: On the b and man who complated cause, M. D. 10	of Injury th, Day Year)  of Injury - At he ing, etc. (Specify the sis of my known asis of examinal ner stated.	28b. Time of thijury  pome, farm, st  whedge, deat tion and/or in  a 23a) (Type,	moccurred at the vestigation, in 29c. Li	tnjury Work 1 T	at ? e, date and inion, deat	No 2 d place, e h occurre	(Check only one 5 Reside 8d. Describe 1 St. Location (San Crity or Tay)  and due to the dat the time,	Ane)  Jenca 6 Ott  Street and Num  m, Stete)  Cause(s) and m  dete and place,  29d. Date signe	ner (Special rred ber or Rum anner as s and due to	tated.  Day, Year)		

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

					Cer	tificate of	Death		Reg. No.	3 6	4409	
	10.0		1. Decedent's Neme (First, Middle, Las	()				2. Deta of De	eath		3. Time of Death	
ļ.	Physicia.	_	Edith G. Spa	arrow				Month	Dey	Year	2 50 25	
	/Medica Examine		4e Facility Name (If not institution, give	street and number)			4b. City, Town, or	Location of Deet	h 4c. County	1999 of Death	3:50 am	
			Anne Arundel Me	edical Cente	r		Annapo	lis	Anne	Aru	ndel	
F	uneral		5. Social Security Number 6. Se	7. Age (In yrs. I		If Under 1 Yea	r If Under 24 Hrs	8. Date of Bir		9. Birthpl	ece (State or Foreign	
D	irector		216-22-3576 Usual Residence of Decedent	<sup>□M</sup> 20 F 10	3 Yrs.	Months Day:	Hours Min	FEB. 2	189	6 Ma	ryland	
ylen	M W		10a. Stete 10b. County	10c. City	, Town or Loc	ation				10	Od. Inside City Limits	
the Mar	r 28a-f ahow inoutled at	오上	Maryland Anne A	Arundel An	napol	is			10g. Citizen of N	Mant Cours	Yes 2 No	
ath with	23a or	rai Or	1819 Johnson Rd			2140	1		US			
Maryland 21215-0020 d 2 should be filed within 72 hours efter death with the Maryland		by Fur	11. Merital Status  1 Never Merried 2 Merried  3 Widowed 4 Divorced	12. Wes Decedent Ever in U,S Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give A Year or Detes:	If	Ves Decedent of Yes, specify Cu ☐ Yes 2 🗓 No	Hispanic Origin? (S ban, Mexican, Puer o Specify:	Specify Yas or No to Rican, etc.)	Ble	ce - America ck, White, e	etc.	
2-C	then "natural", he Wedical Exp	Completed	15. Decedent's Edu (Specify only highest grad		16a. Deced	ent's Usuel Occi	upation e during most of wo	rkina	16b. Kind of B	usiness/Ind	ustry	
within	CM	d	Elementery/Secondary (0-12)	College (1-4or 5+)	life. D	O NOT use retir	ed)	nay				
d 21	Tr. Car	0	3rd.	0	Do	mestic			Home			
D # 1	1 2 2	Q Q	17. Fether's Name (First, Middle, Last)				18. Mother's Ne	me (First, Middle	, Maiden Suman	16)		
arylan	T S	- 1	John T. Gross J	r.			Julia	A. Duke	9			
2 she			19e. Informant's Neme/Reletionship (T	ype, Print)	19b. Meiling	g Address (Stree	et and Number or R	ural Route Numb	er, City or Town,	State, Zip	Code)	
6.5	7. T		James Carter(Gre				on Rd.	Annapol	lis, Mo	1. 21	401	
Baltimore,	If item 2 or other		20a. Method of Disposition  1 Daugher 2 Cremetion 3 1		ece of Dispos emetery, crem	sition (Name of setory or other pi	lece)	Dete	20c. Location -	City or Tov	wn, Stata	
Pag Pag	H C		4 □ Donetion 5 □ Other (Specify)		anoli	s Neck		7_8_99	Annanc	lie	БМ	
mit.	mportant: iny injury ince		21. Signeture of Funeral Service Licens		22.	Neme end Add	ress of Facility					
n aa	EES		Manny A	. Legge	W	m. Ree	se & So	ns Mort	uaru,	P.A.	0.1	
		+	23a. Pert1. Enter the disease, or comp	lications that caused the death			t St. A			214	Approximate	
Phy	hysician		shock, or heart feilure. List only o	ne cause on eech line.							Intervel Between Onset and Death	
, .	ledical		Immediate Cause (Finel	2	47						-	
Exa	aminer		disaesa or condition resulting in deeth)	· PASUMON							5 0,245	
		6			as a consequ							
Pet	insit.			b. PERIPHER			NE DISE	ASE			YENRS	
, and	-tra	Sequentially list conditions, if any, feading to immediate acquires. Enter Underlying										
20 8	physician and s the burial-transit	8	cause. Enter Underlying Cause (Disease or injury that initiated events	c HYPERTE							YEARS	
C 58/50, rtificate be executed	0 11	Medical	resulting in death) Last	Due to (or	as e consequ	ience of):						
death cent	signed by the attendir	Physician	Darf # Other classificant conditions on		him to the second	424	in the Park	nah pud	4-1		the cause of death?	
that the d	y the	D S	Part If. Other significant conditions co		mang an une un	deliying cause ç	premim Perci.		Yee 2010		nably 4 Unknow	
that	e det	Dy T	BREAST C	ancer				10	2010	00,7100	abiy 4 onknow	
DIVISION OF VITAL RECORDS, for Attending Physician: The law requires the death.	been sig should b	Desc						24a. Wes	an autopsy ormed?	ava	ere autopsy tindings ailable prior to appletion of cause	
Me le w	9 N 1	Completed								of c	death?	
מ ב	certificate rector, pag	2	25. Wes case referred to medical						Yes 275 No	1	Yes 2 No	
2 5	rector	0	examiner?	Hospital:		5	thor	eth (Check only				
Of VITA	this co		1 Yes 2 No	1 pa Inpatient 2 LE	ER/Outpatient 28b. Time of	3LJ DON	4 Li Nuising i	dome 5 ☐ Resi	how injury occur		)	
D #	After fune		1 Salaturel 5 Pending	(Month, Day Year)	Injury	28c. fnj W	ork? □Yes 2□No	200. 0030.00	now injury occur			
Man death	the the	2	2 Accident investigation 3 Suicide 6 Could not be	29a Disea of taken. At he		29f Location /	Street and Numb	har or Pura	I Pouts Number			
No P	in by		4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	ma, ram, stre	et, lactory, offici		City or To		er or nurar	Houla Number,	
To the Hospital or Attending F within 24 hours after death.	To the Funeral Director: After this centificate ha completely filled in by the funeral director, page	27. Menner of Death 1 Claurel 2 Accident 3 Suicide 4 Homicide  28e. Place of Injury - At home, farm, street, factory, office 29e. Certifier (Check only one)  28e. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No  28d. Describe how injury occurred										
he H	Pleta	3	one) 2   Medical Exami	ner: On the basis of examination and manner stated.	on and/or inv	estigation, in my	opinion, death occi	urred at the time,	uete end place,	and due to	tne cause(s)	
Tota	Toth		29b. Signature and title of certifier			nse number		29d. Date signe		Day, Year)		
			108		6	NO -	D3507	37	7/5	199		
			30. Name and address of person who co	ompleted cause of death (Item	23a) (Type. F	Print)						
		149	DOUGLAS 5 MITCH	ELL, ANDE 1	1RUND	EL MEDI	COC CENT	ER, An	NARU	S M	0	
	State		31. Dete filed (Month, Day, Year)	32. Register's Signate								
	Registra		JUL 49 19	59 Johnson	D.	Loo	AL.					

M 08 100 pm p. from

P.O. Box 68760, Division of Vital Records,

The law requires that the death certificate be executed

or Attending Physician:

Hospital

EP.

Baltimore, Maryland 21215-0020

this After t death. filled in by the efter death within 24 hours of To the Funeral C completely

27. Menner of Deeth 5 Pending investigation 1 Yes 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Siegature and title of certifier

the and Allereider Min

19

1999

29c. Licansa number

29d. Data signed (Month, Dey, Year)

Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

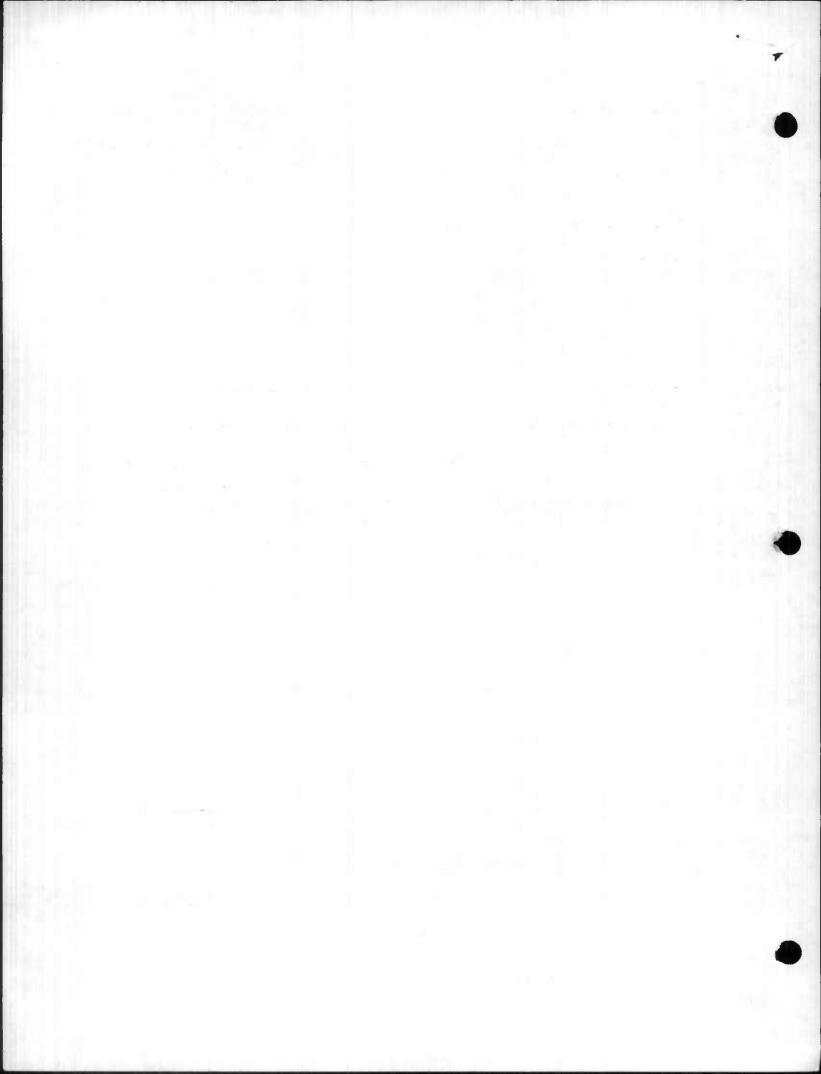
540 1 MACARTHUR BUSMU WASHE 20016 MARTH AME SCHNESSER AD

State Registrar

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31. Dete filed (Month, Day, Year)

32. Ragistrer's Signeture



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9-4122-005	Ple	ase Type or P	Print In B	lack In	delible in	k. Assu	re All Copie	es Are Leg	gible.	
JEFFREY		State of	Maryland	d / Depa	artment of	Health a	and Mental H	Hygiene (	19 2	1.1.11
STERLING				Cei	rtificate o	f Death		Reg. No.	) ) [	. * * 1 1,
	1. Decedent'a Nama (First, Mid	idia, Last)					2. Data of Month		Year	3. Time of Death
Physician /Medical	JEFFREY TH	OMAS ST	ERLING				JULY	Day 14,	1999	12:25P.M.
Examiner	4a Facility Nama (If not institut					4b. City, To	wn, or Location of D	eath 4c. Cour	nty of Death	
	6 DALMENY COUF	TS					VILLE	BALT	IMORE	
Funeral	5. Social Security Number	6. Sex 7	. Age (In yrs. la		If Under 1 Ye Months Day			Birth Day, Year)	9. Birthple Count	aca (Stata or Foraign
Director	532-70-2385	- Law 20 F	43	Yrs.			April	18,1956		
2 1-	Usual Rasidence of Decedent  10e. Stata  10b. Coun	nty	10c. City,	Town or Lo	ocation				10	od. Inside City Limite
-0020 hours after death with the Maryland hurst', or terms 23s or 28s-f show at Examiner must be notified at ad by Funeral Director	Maryland Bal	timore	Pa	rkvil	le					1 ☐ Yes 2 ☐No
or 28a-1 be notifie Directo	10e. Street and Number				10f. Zip Code	9		10g. Citizen o	of What Count	ry?
23a o unit be	6 Dalmeny Co	urt, Apt. 3	01		21234	4		USA	1	
her death v r hame 23a siner.must Furneral	11. Marital Status	12. Was Deced	lent Ever in U.S	S. 13. Y			gin? (Specify Yas or , Puarto Rican, atc.)		ace - Amarica	
or the miline or the	1 Never Married 2 M	arried Armed Ford	2 □ No		1 □ Yas 2 □XN		i, ruano nican, atc.,		lack, Whita, e	
DO2	3 ☐ Widowed 4 ☒ Divorce	ed Year or Dat			TO THE ZUAN	о эрвану.		Spec	whi	Lte
72 h Tath disa	15. Deced (Specify only high	ent's Education hest grada completed)		16a. Deced (Giva	dent's Usuel Occ kind of work do DO NOT use ret	cupation na during mos	t of working	16b. Kind of	Businass/Ind	ustry
1 21215-0 ad within 72 ho vyglene. In the Medical. Completed	Elementary/Secondary (0-12	College (1-4	4or 5+)			ired)			Tell 1	
d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2	17. Fathar'a Nama (First, Middl	a I act)		Sale	sman	18 Moths	r's Nama (First, Mio	METE		
E sage m	Norris P. St						cia Anne		J. 1.0	
should Mer marks marks and Mor	19a. Informant's Name/Ralatio			19b. Mailir	na Addrass (Stre		er or Rural Routa Nu		vn. Stete Zin	Code)
Baltimore, N permit. Pages 1 and Department of Health Important. If Item 27 any Injury or other It and any Leafth	20a. Mathod of Disposition  1 🖾 Burial 2 🗆 Cremation  4 🗆 Donetion 5 🗀 Other  21. Signature of Fundual Service	(Specify)	tata Sto	newal:	nation (Name of matory or other parties of Memory  Name and Add	olace) y Garde drass of Facility	Y TENNA EIN	Manass	sas, Va	wn, Stata
	23a. Part1. Entar the disease, shock, or haart failura. Li	1 salle	upped the death	Do not out	171 W. N	Maple A	ve., Vien	na, Va.	22180	
Dhusisian	shock, or heart failure. Li	ist only ona cause on aa	ch lina.	. Do not ent	er the mode or c	rywig, such as	cardiac of raspirator	y arrast,		Approximata Intarval Batween Onset and Death
Physician /Medical	Immediata Cause (Final	0			1 11	10.04.0	-01-		- !	
Examiner	diseasa or condition rasulting in death)	a. 00 N		as a conseq		70000	OFHEDS	)	1	
j	C		500 10 (01	as a conseq	querice orj.				1	
e executed ian and unal-transit	Sequentially list conditions,	b	Due to (or	as a conseq	juence of):				1	
0 - 4 -	if any, laading to immediata cause. Enter Underlying	,								
0 A O A	Cause (Disease or injury that initieted events rasulting in death) Last	C	Dua to (or	as a conseq	uence of):				1	
Box 687 death certificate e attending phys d for use as the										
Box ath cert for use		0.							1	
O. In the decrete ched it	Part II. Other significant condi	tions contributing to dea	nderlying causa	given in Part I	. 23b. (	Old tobacco una	contributa to	the cause of death?		
	DIPPOSE PSORIBILS							Yaa 2 No	3 ☐ Prob	ably 4 Unknow
dS, ires the signed does do be									nah Wa	re cutana findina
requirements to the second should be second should should be second should should be second should sho								Vas an autopsy erformed?	ava	ra autopsy findings iilable prior to apletion of cause
Rec e law has b								/		death?
al Re to cate he cate							•	e Yas 2□No	118	Yas 2 No
Vital I	25. Was case refarred to medic axaminar?	Hospital:				26. Place Other:	of Death (Check or	nly ona)		

To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di Division of Medical Certification:

28d. Dascribe how injury occurred

27. Manner of Death 28a. Date of Injury (Month, Day Year) 1 Netural
2 Accident
3 Suicide 5 Pending investigation 14 99 6 Could not be determined

28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 28a. Place of Injury - At homa, ferm, street, fectory, office building, atc. (Specify)

SUBJECT SHOT SELF. 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta)

29a. Certifier (Check only one)

4 Homicide

6 DALHENY CT PARKVILLE BALTINGE RESIDENCE 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated.

O.C.M.E.

29b. Signature and titla of certifier

29c. License number

29d. Data signed (Month, Day, Year) JULY 15,1999

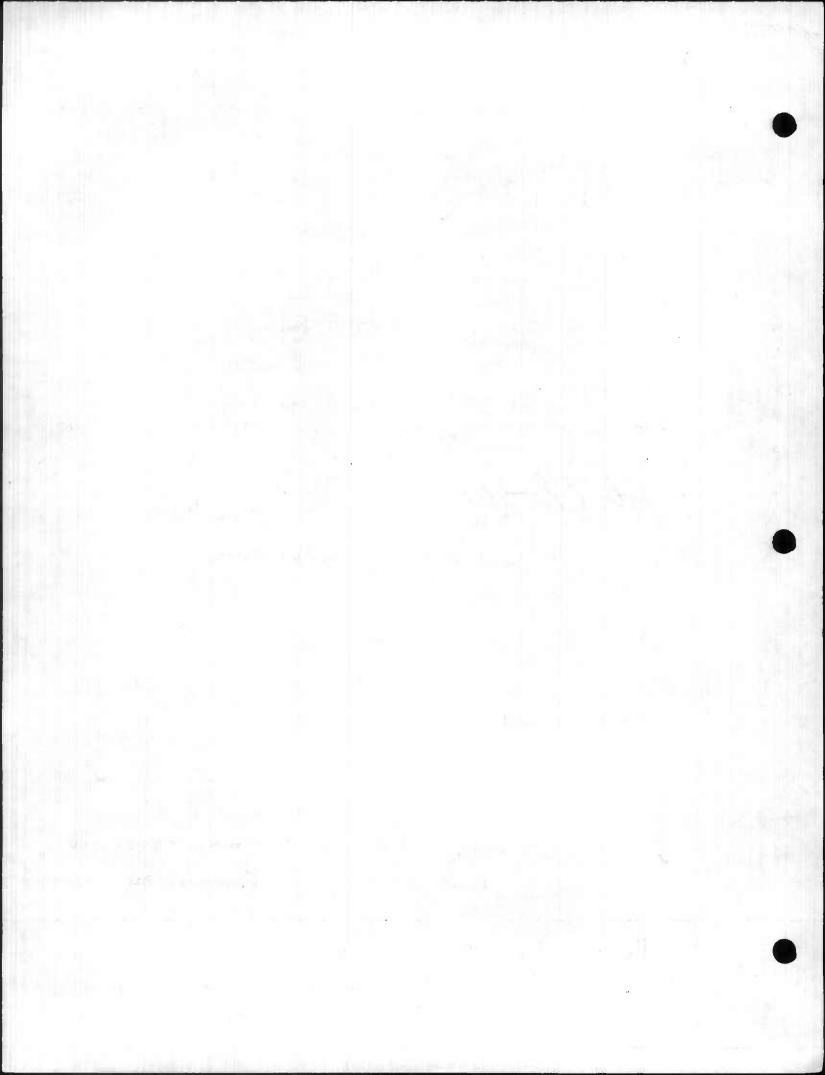
30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person in the Company of th

State Registrar

32/Registrar's Signatura

111 Penn Street, Baltimore, Maryland 21201

6



State of Maryland / Department of Health and Mental Hygiene 99

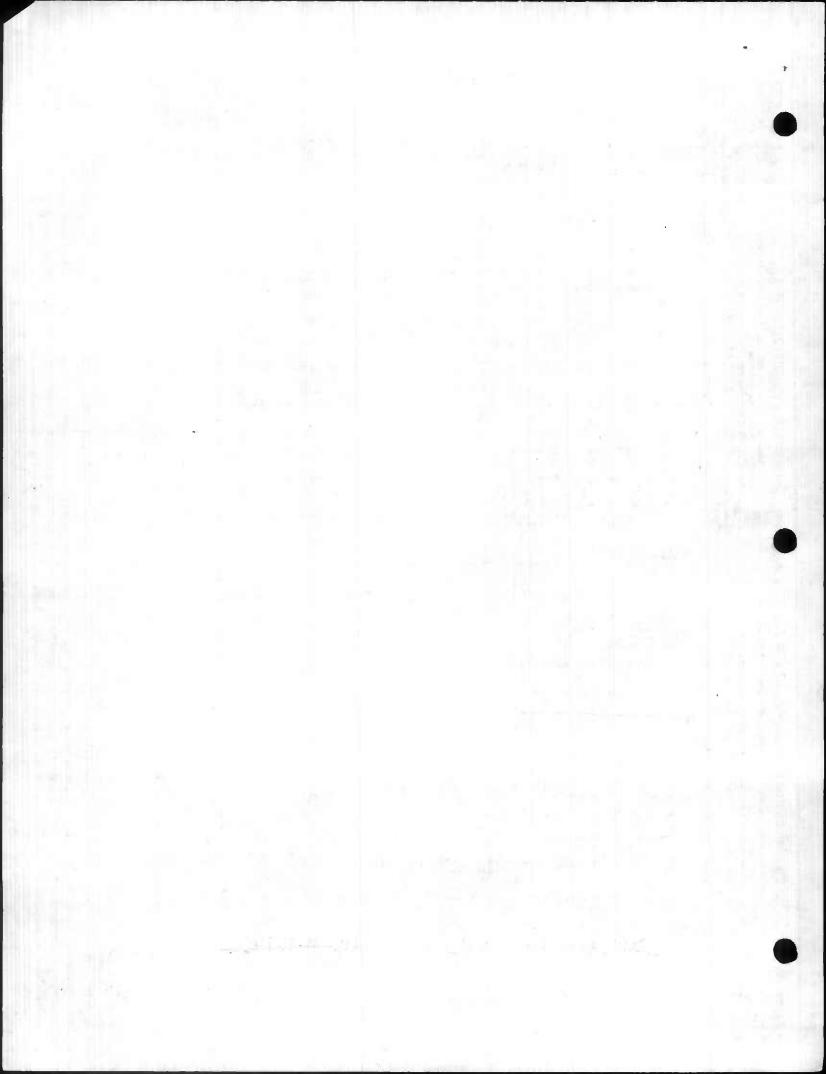
Certificate of Death 1. Decedent'e Neme (First, Middle, Last) 2. Date of Deeth **Physician** OTTO THOMAS 1:43 PM STEINER /Medical 4e. Fecliity Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner DOCTORS HOSPITAL LANHAM PRINCE GEORGE If Under 1 Year If Under 24 Hrs. 8. Dete of Birth Months Days Hours Min. NOV . 1 2 1 9 1 7 5. Sociel Security Number 6. Sex 1X M 2□ F 7. Age (In yrs. lest birthday) 9. Birthplece (Stete or Foreign **Funeral** CZECHOSLOVAKIA 099-14-2519 81 Yrs Director Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f shor must be notified at MD P.G. LANHAM Director 1 ☐ Yes 2 ☐ No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 9001 SPRING AVENUE 20706 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 □ No It Yes, Give Yeer or Detes: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Rece - American Indian, Black, White, etc. 1 Never Merried 2 Married ò 1 ☐ Yes 2 X No Specify: þ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 4YRS COMPUTER PROGRAMMER NASA 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) . Pages 1 and 2 should be fill therit of Health and Mental H tant: If them 27 is marked off Be EMIL STEINER AMALIA OHRENSTEIN 19e. Intorment's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) nt of Health a If them 27 is r or other tra 9001 SPRING AVENUE, LANHAM, MD. 20706
Dete 20c. Location - City or Town, Stete YVONNE STEINER (WIFE) 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20e. Method of Disposition GEORGETOWN MED SCH.7/13/99 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from State WASH, D.C. 4 Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility
AUSTIN ROYSTER FUNERAL HOME
3821 14TH ST. N.W., WASH, DC. 20011 21. Signeture of Fungrel Service Licenses JOZI 14TH ST. N.W., WASH, for complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Intervel Betw Physician Aspiration
Due to (or es e consequence of): mediate Cause (F) disease or condition resulting in death) Examiner infarction Physician/Medical Examiner Acute myocardial 7 Hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760, 8 Due to (or es e consequence of) P.O. Pert ti. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Coronary artery disease Division of Vital Records, à 24b. Were autopsy tindings eveilable prior to completion of cause of death? Completed 24e. Wes an autopsy performed? The law 1 Yes 2 No 1 Yes 2 No Be 25. Wes cese reterred to medical examiner? 26. Plece of Death (Check only one) 1 ☐Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 9 27. Menner of Deeth 1 Neturel Certification: 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Affac 5 Pending investigation ours after deab. 1 Yes 2 No 2 Accident 3 Sulcide 6 Could not be determined 28e. Plece of Injury - At home, term, street, tectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital o within 24 hours at To the Funeral D Medical I Cartifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) end manner es steted.

□ Madicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end manner steted. 29a, Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) D31089 of berson who completed ceuse of deeth (Item 23a) (Type, Print) FUTCOVICH, 8201 Corporate Drive, Suit 620, LANDOVER, MD 20785 31. Dete tiled (Month, Dey, Year) 32. Registrer's Signeture State Registrar 20

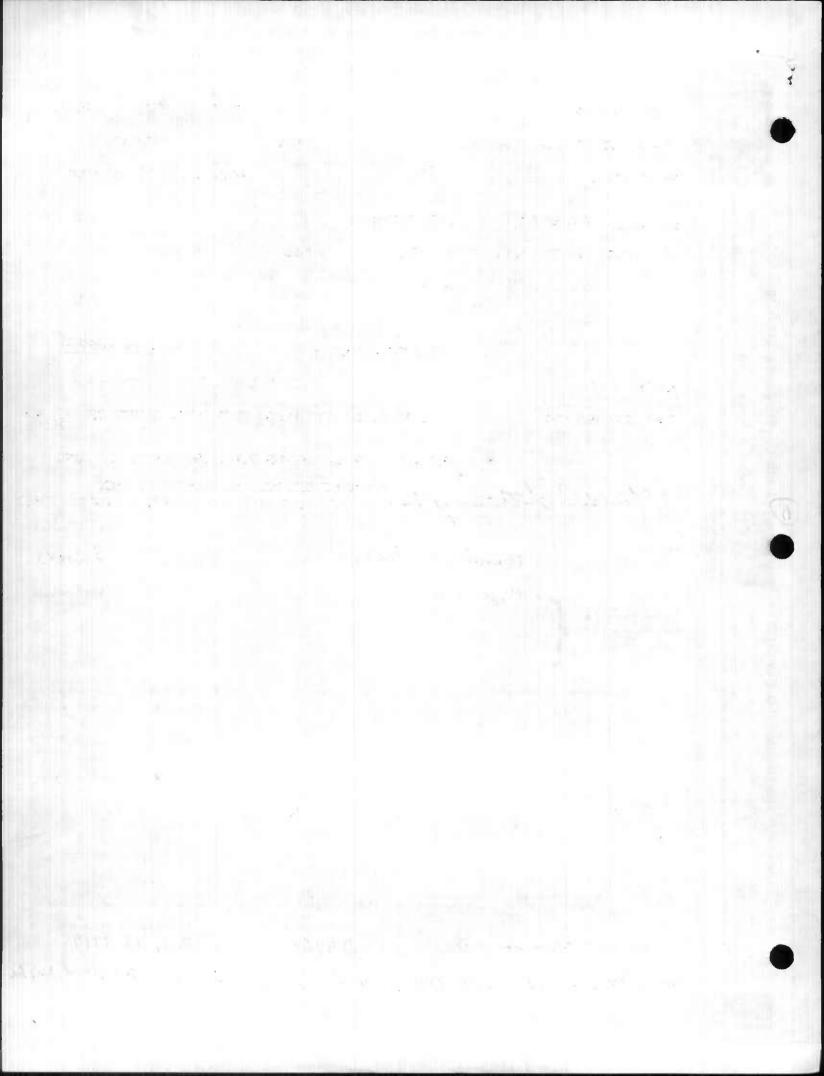
And Langer Man Land And Design of the Control of th

State of Maryland / Department of Health and Mental Hygiene

	29c,7/21/99,BMW 1. Decedent's Name (First, Middle,							2. Date of Dec	Reg. No. ath Dey	Year 3.	Time ol Death
/sician ledical	William Frank St	evens Jr.						July 15	,1999		4:35pm
iner	4a Facility Name (If not institution,	give street and number	r)			4	b. City, Town, or I	Location of Death	4c. County	of Death	
	10401 Grosvenor				If Under 1		ockville			omery	
ral tor	5. Social Security Number 200–28–8191  Usual Residence of Decedent	6. Sex 7. A	Age (In yrs. las	Yrs.		Days	Hours Min.	8. Date of Birt (Month, Da) Jan. 17	y, Year)	9. Birthplace Country) Pennsy.	(State or Foreign Lvania
	10a. State 10b. County		10c. City,	Town or Loc	ation						nside City Limits
Directo	Maryland Montgom	ery	Rocky	ville						1	XYes 2 □ No
	10e. Street and Number 10401 Grosvenor	D1 #22	0		101. Zip 0				10g. Citizen of \	Whel Country?	
by Funeral	11. Marital Status  1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Deceder Armed Forces	it Ever in U,S. 37 ] No	M	/as Decede	ent of Hi fy Cuba	ispanic Origin? (S n, Mexican, Puert Specity:	pecify Yes or No- o Rican, etc.)	Blad	e - American Ir ck, White, atc. White	ndian,
Combined	15. Decedent's (Specify only highes) Elementary/Secondary (0-12)		5+)	life. D	and of work O NOT use	k done d e retired	luring most of wor )	king	16b. Kind of Bi		у
	1.2 17. Father's Name (First, Middle, L	acti		Labora	tory	Tec	hnician 18. Mother's Nan	na /First Middle	NIH, N		
2	Unknown	/					Jnknown	(ra., moule,	a.our ourier		
	19a. Informant'a Neme/Relationshi	ip (Type, Print)		19b. Meiling	Address		and Number or Ru	ral Route Numbe	er, City or Town,	Stete, Zip Cod	le)
	Julia H Doherty/	Wife		11823	Breto	on C	ourt #22	c Restor	, VA 20	191	
	20a. Method of Disposition  1 Burial 2 Coremation 3  4 Donation 5 Other (Spe		0 007	ce of Disposi netery, cremi opolit	atory or oth	her plac		July 16	20c. Location -		Slate
	21. Signation of Funeral Service Li	consee		Fr	ancis	J.	collins				AD 20001
Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initieted events resulting in death) Last	b. Infect.	ion of Due to (or e	the possedure a consequence a	rosta ence of):	ite					
Physician/M											
	Part II. Other significant condition  Infection of pro		but not resulti	ing in the und	derlying ca	use giv	en in Part I.				cause of death?  4 13 Unknown
								24a. Was perlo	an autopsy med?	availab	utopsy findings le prior to ition of cause h?
Completed								101	res 2 ₩ No	1 ☐ Ye	s 2□No
Be	25. Was case referred to medical examiner?	Hospital:				Oth	Der:	eth (Check only o			
-To	1 Yes 2 XNo	1 ☐ Inpat	ient 2 EF	8b. Time of			4 LI Nursing H	ome 5 🖾 Resid			
Certification:	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	(Month, D	ay Year)	Injury	М		(? Yes 2 No	28f. Location (\$			uta Numbar
Ē	4 Homicide determin	building, e	njury - At hom etc. <i>(Specify)</i>					City or Tou	m, State)		4 ( )
	29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the best taminer: On the basis and manner s	of examination	edge, death on and/or inve	occurred a estigation, i	t the tim in my op	e, date and place pinion, death occu	, end due to the orred at the time,	date end place,	and due to the	ceuse(s)
edical	ane)				200	License	number D-0	126557	20d Data ciana	d (Month, Day,	Year)
edical		en	Com		F	~	# 1171	1	July 15		
Medical	ane)				rint)	~	# Washing	12	July 15	,1999	



DHMH 16 Ray 6/95



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sician								Month	Day		3. Tima of Death
edical Gar	nett		h, Sr.					July	17,	1999	8:10am
miner 4a Facility Nama						4b. City, Tow			4c.	County of Deat	h
VAMHCS E	ort Howa	ard Divis	sion			Fort		-		Baltimo	re
5. Social Security I	Number 6	Sax	7. Aga (In yrs.		If Undar 1 Ya		4 Hrs.	B. Data of Birtl (Month, Day	h v. <i>Year</i> )	9. Birt	hplaca (Stata or Foraign buntry)
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Usual Rasidance of	-		10.00								Landa de la landa de la landa
10a. Steta	10b. County		10c. Cr	ity, Town or Loc	cation						10d. Inside City Limits
MD  10e. Street and No			Ва	altimore	е						1 Yes 2 No
10e. Street and Nu	mber				10f. Zip Code				10g. Citiz	en of What Co	ountry?
3620 E11 11. Marital Status 1 Never Mer	mley Ave	nue			212	13			U.S.	. A .	
11. Marital Status		12. Wes Dece	edent Evar in U	J,S. 13. V	1	f Hispenic Origi uban, Maxican,	in? (Spec	ify Yas or No-		4. Race - Ama	
1 Never Mer	riad 2 Merried	Armed Fo					Риало Н	ican, etc.)		Black, White	a, atc.
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	15. Decedant's	Education		16a. Deced	ant's Usuel Occ	upation			16b. Kir	nd of Businass/	
	cify only highast	grada complated)	1.4005.3	(Giva I	kind of work don OO NOT usa ret	a dunna most o	of working	7			
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Robert						Line	ic II	1111-1			
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	5 ☐ Othar (Spe			ld Fello	ows Cem	etery	7/:	24/99	Far	rmville	, Virginia
21. Signatura of F	unaral Sarvice Lic	censee				rass of Facility		1 C		T	
X	Lon	1 /11	At 8		_	litan F					210
23a. Part1. Ente	tha disaasa, or co	omplications that conty one causa on e	ausad tha daa	th. Do not ante	er tha mode of c	ne Stre	ardiac or	raspiratory ar	rest,	VA ZZ	Approximata
shock, or he	art failura. List or	ity one causa on e	each lina.								Intarval Batween Onsat and Death
Immediata Causa		Coxox	and Ho	and Dia	0250						Vann
disaasa or conditi rasulting in daath)		a. COLOI		art Dis							Years
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that initiated avant	r Injury	c	Dua to (	or as a consaq	uanca of):						
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Ceusa (Diseasa of that initiated avaninasuiting in death)  Part III. Other signi	is Last  ificant conditions  Important	s contributing to de	Dua to (d	or as a consage	uanca of): uanca of):	givan in Part I.		1 □ ¹	Yes 2	□ No 3 □ P	wara autopsy findings available prior to
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DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020 Name: Garnett Smith

Division of Vital Records, P.O. Box 68760,

tild gri vard. Hva Observe Care News

The transport time that the past of the last time to be the

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🏻 🥄 Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Month JAMES POUGLAS SHORT 4a. Facility Nama (If not institution, giva streat and number) 4b. City, Town, or Location of Death 4c. County of Death ELDERCARE SILVER SPRIK WOODSIDE CTR-GENESIS MONTGOMERY 7. Age (In yrs. last birthday) If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 6 Sex 8. Date of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) 12 M 2□ F Hours 58 7754 418 41 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Montgomery 1 ☐ Yas 2 ☐ No Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3238 Hewitt Avenue #37 20906 USA 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puarto Ricen, etc.) 14. Race - American Indian, Biack, White, atc 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☒ No Black Spacify 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Construction Worker Construction 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middla, Maiden Sumama) Bernard Short Dorothy Matilda Collins 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) Vera Lowery/ Sister 421 West 162 Street #5E, New York, NY 10032 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) July 22 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 1999 Alexandria, VA 21. Signature of Funeral Service Licensea 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 23a. Part Enter the disease, or complications the caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock or heart failure. List only one ceuse on each line. 500 University Blvd W., Silver Spring, MD 20901 Approximata Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) a Squamous cell cancer of tongue Sudden Due to (or as e consequence of): b. Metastatic cancer Sequentially list conditions, if any, leading to immediate ceuse. Enter Undarlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of ceusa of death? 24e. Wes an autopsy performed? Candida esophagitis 1 ☐ Yes 20 No 1 Yes 2 No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 X Natural 5 Pending Investigation 1 Yes 2 No 2 Accident 3 Suicide

that the death certificate be executed attending physician and for use es the bunel-tran P.O. Box 68760, á signed b Records, The law requires page 2 s certificate Division of Vital Hospital or Attending Physician: To the Hospital or Attending Prysis within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral directors. After this

**Physician** 

/Medical

Examiner

Director

Funeral

þ

Completed

.Funeral

Director

7 is marked other than "natural", or items 23s or 28a-f show traumatic event, the Medical Examiner must be not the at

permit. Peges 1 and 2 should be filed within 72 hours efter. Department of Health end Mental Hygiene. Important: If fem 27 is marked other than "natural", or her any injury or other traumatic event

**Physician** /Medical

**Examiner** 

Examiner

Physician/Medical

by

Completed

Be

2

Certification:

Medical

Baltimore, Maryland 21215-0020

the Maryland

death

Anemia 25. Wes cese referred to medical

1 Yes 21 No 27. Manner of Deeth

6 Could not be determined

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Location (Straat and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier 29b. Signatura and title of certifier

4 - Homicide

tic Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the ceuse(s) and menner stated. 29c. Licanse number 29d. Data signad (Month, Day, Year)

D32332

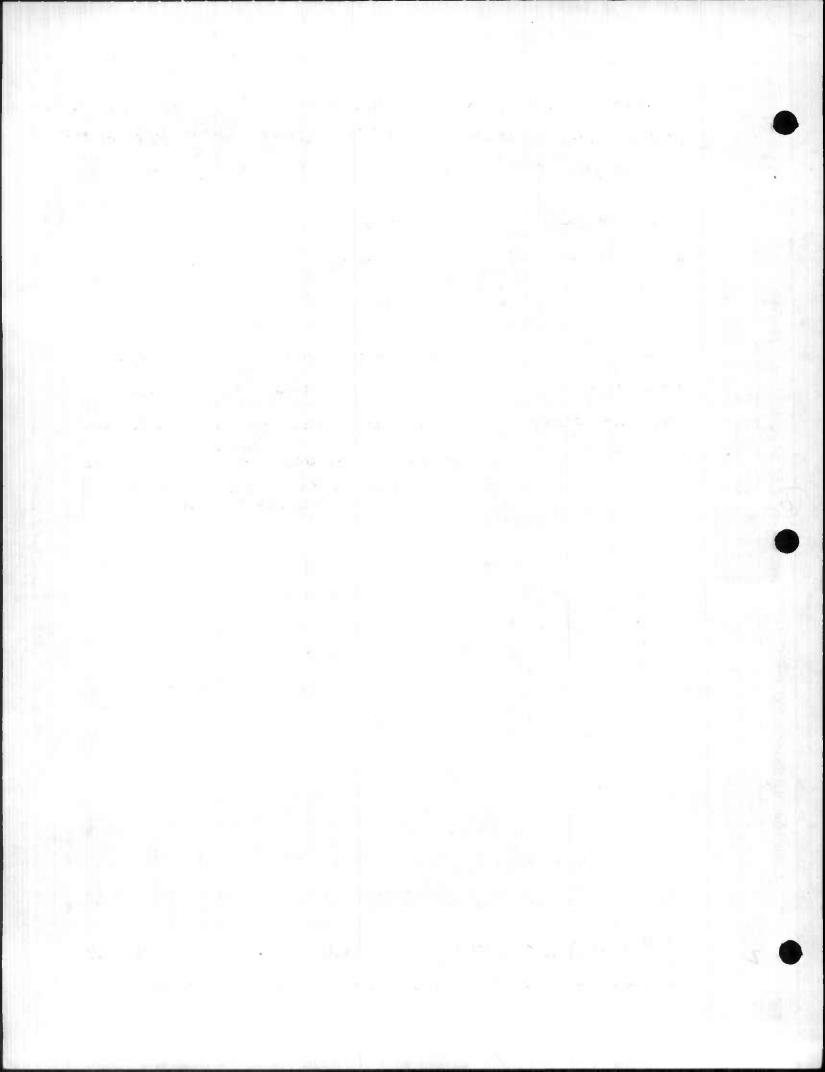
July 22, 1999

30. Neme end eddress of person who completed cause of deeth (item 23e) (Type, Print)

Suresh Kumar Gupta, MD 9801 Georgia Ave, #220 Silver Spring, MD 20902 31. Date filed (Month, Dey, Year)

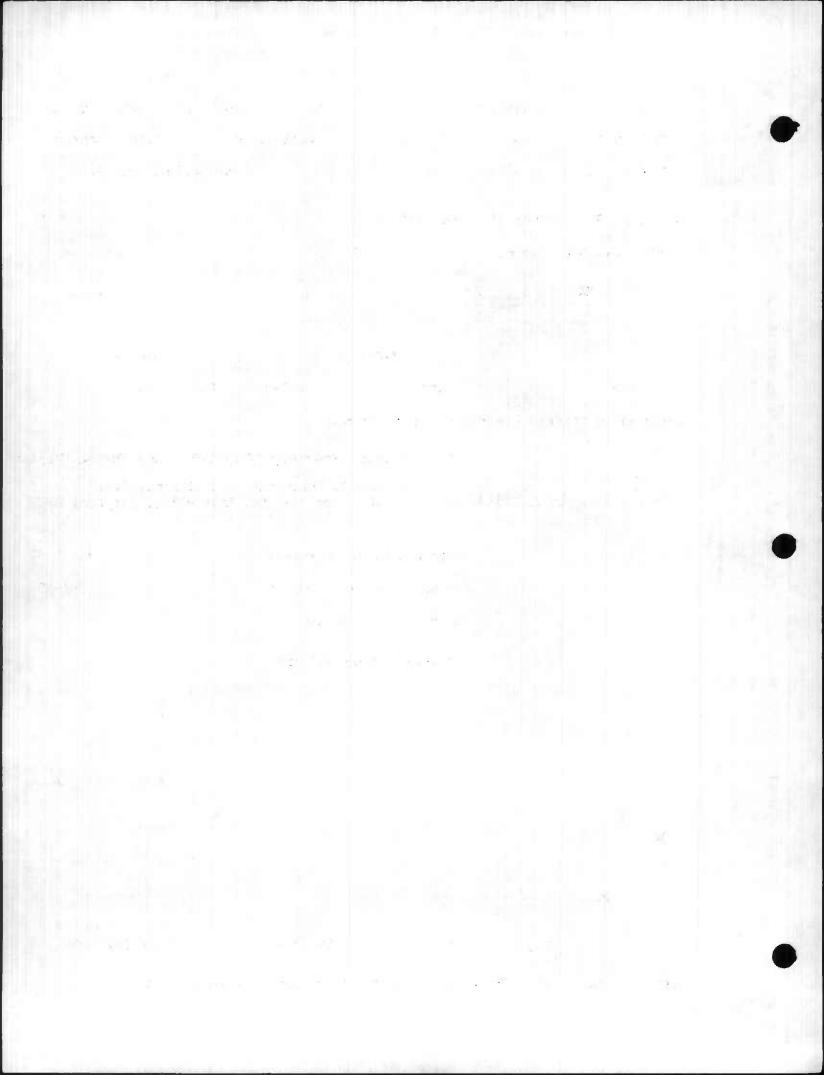
State Registrar

23 1999 32. Registrar's Signeture



State of Maryland / Department of Health and Mental Hygiene 99 2447

			Ce	rtificate of	Death		Reg	. No.		
	1. Decedent's Name (First, Middle, L	est)					e of Death		Vans	3. Time of Death
Physician /Medical		Annette		Sha	ank	Ju		Dey 19	Year 99	7:15A.
Examiner	An English Blome Mont institution of				4b. City, To	wn, or Location	-	4c. County	of Death	eorge's
Funeral Director	213-24-4147	Sex 7. Age (In yrs	last birthday, 86 Yrs.	Months Day		Min. 8. Dat Min. Au	e of Birth onth, Day, Y	1912	9. Birthp Cour Mary	lace (State or Foreign Land
Aaryland I show	Usual Rasidence of Decedent  10a. State  10b. County  Maryland Prince		ity, Town or L							0d. Inside City Limits 1 ☐ Yes 2√2 No
the N	10e. Street and Number	ocorge o pe	TODVII.	10f. Zip Code	4		100	. Citizen of \	What Cour	
of the death with the Ma writems 23a or 28e4 s the must be notified for must be notified	4502 Josephine	Avenue		2070	5			Unit	ed S	tates
ons on service by	3 ☐ Widowed 4 ☐ Divorcad	12. Wes Decedent Ever in the Armed Forces?  1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	J,S. 13.	Wes Decedent of If Yes, specify Cu 1 ☐ Yes 2 No.		nn? (Specify Ye, , Puerto Rican,	etc.)		ca - Americ ck, White, y: W	
15-0 n 72 hc n 72 hc	15. Decedent's E (Specify only highest ga	ducation ade com <i>pleted</i> )	(Give	edant's Usuai Occi	e during most	of working	16	b. Kind of B	usiness/in	dustry
1 21215-0 ed within 72 ho ygiene. er than "neture nt, tre Wolfert	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retii maker	red)			OWN	home	
Hied Hygin	17. Father's Name (First, Middla, Las	t)	1104.104		18. Motha	r's Name (First,	Middle, Ma			
yland 212 yland 212 ould be filed with Mental Hygiene. erked other ther afte event, the	William		Bean		He1	en	C.	Cuff		
2 2 a s a	19a. tnformant's Name/Ralationship Helen Alice Grift			ing Address (Street	et and Numbe	er or Rural Route	Number, (	City or Town.	, Stata, Zip	Coda)
	20a. Method of Disposition  XXBurial 2 Cremation 3   4 Donation 5 Other (Spec	Bemoval from State	cametery, cre	osition (Name of ematory or other position Control Con		Date y 7/21/		c. Location		wn, Stete ing, Marylar
Baltimo permit. Page Department of Important: If any Injury or pncs.	21. Signature of Funeral Servica Lice	Boand	Do	2. Name end Add	Borgwa	ardt Fur				and 20705
Physician	23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused the dea y one causa on each line.	ith. Do not en	nter the mode of d	ying, such es	cardiac or respi	ratory arres	t,	Maryı	Approximete Interval Between Onset and Death
/Medical Examiner	Immediate Causa (Final disease or condition resulting in death)	a. Isch	aemic	Heart Di	sease					10-10-97
يَ السَّاسِ ا		Dua to (or as a consequence of): Peripheral Artery Disease								
5x 68760, certificate be executed refing physician and use as the bunishransit	Sequantially list conditions, if any, leading to Immediate cause. Enter Underlying Causa (Disaasa or injury	Due to (or as a consequence of):  Chronic Renal Failure								
376( ata be nysicia he bur		c	or as a conse		.ure					
M Ban		d. Cong	gestive	Heart F	ailure					
- 0 0 X	Part II. Other eignificant conditions	contributing to death but not re	sulting In the	underlying cause (	givan in Part I	. 23		1		the cause of death?
E X TO							1 🗆 Yes	2 No	3 Pro	bably 4 Unknown
0 > 110 =						24	a. Was an performe	eutopsy ed?	av cc	ere autopsy findings aileble prior to mpletion of cause death?
Vital Re- sicien: The law certificate has rector, page 2							1 🗆 Yes	2 No	1 (	☐ Yes 2 No
f Vita yslclan: s cartific director,	examiner?	Hospital:			Whor:	of Death (Chec				
Of Vita Physician: this cardiforal director,		1 L Inpatient 2L	28b. Time	ant 3LI DOA	4 LI NU		1	ca 6 □Ott	-	(y)
Division of the or Attending Practice of Olivector: After the funers and in by the funers Certification:	1 Natural 5 Pending 2 Accident Invastigation 3 Suicide 6 Could not	ne -	Injury	M 1	□Yas 2□	No				al Route Number,
Divi	4 ☐ Homicida determine	28e. Place of Injury - At l building, atc. (Spec	ify)	treat, factory, ome	a	Ci	y or Town,	State)	567 6771676	arriodio rumbor,
Division or within 24 hours after death within 24 hours after death completely filled in by the funeral Medical Certification:		hysician: To the best of my kn mtner: On tha basis of axamin and manner stated.								
Vithii Withii Comp				29c. Lice	nse number		290	d. Date signe	ed (Month,	Dey, Year)
1-	No.	M		DO	013668			July	19,	1999
Y	30. Name and address of person who Azher Hussain, M				ege Par	k, Mary	land	20740		
State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	Span		•				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3 Time of Death Physician JULY 17, GRACE SHAW 1999 4:05 AM /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner MANOR CARE - POTOMAC **POTOMAC** MONTGOMERY 5. Sociel Security Number if Under 1 Year if Under 24 Hrs. 7. Age (In yrs. last birthdey) 8. Dale of Birth Month, Day, Year 923 **Funeral** 9. Birthplece (State or Foreign 1 M 2 S F Months Days Hours Min PENNSYLVANIA 191-16-9206 75 Director Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City. Town or Location show 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f si other traumatic event, the Medical Examiner must be notified Director 1 Yes 2 □ No MARYLAND MONTGOMERY ROCKVILLE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whal Country? with 10 LILY POND COURT 20852 UNITED STATES Funeral 11. Marilai Status Was Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian Biack, White, etc. 1 Never Merried 2 Married I ☐ Yes 2 X No If Yes, Give 1 ☐ Yes 2 ☒ No Specify: WHITE þ 3 Widowed 4 Divorcad Year or Detes: Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/industry NEW YORK CITY Elementery/Secondary (0-12) Coilege (1-4or 5+) TEACHER PUBLIC SCHOOLS 5+ 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Surneme) Be ARCHIBALD ABRAMS HILDA KLEIN 2 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 10 LILY POND COURT - ROCKVILLE, MARYLAND 20852 NANCY REINER (DAUGHTER) 20b. Piece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 X Buriel 2 Cremetion 3 Pamoval from State 7/22/99 BETH MOSES CEMETERY PINELAWN, NEW YORK 4 □ Donation 5 □ Other (St ity) 21. Signature of Funecal S DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE - ROCKVILLE, MARYLAND 20852 Part 1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset end Deeth Physician /Medical Finel disease or condition resulting in deeth) FIBRILLAMOR VENTRUCKINE Examiner Due to (or es e consequenca of): Examiner The law requires that the death certificate be executed the burial-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last and Due to (or es e consequence of): signed by the attending physician be detached for use as the buria Physician/Medical Due to (or as a consequence of): for use as Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ANFWIA þ Completed 24b. Were autopsy findings evailable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? DRZP VANOUS THROUBESIS certificate has 2 No 1 ☐ Yes 2 DINo Hospital or Attending Physician: Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Other: 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ♦ Nursing Home 5 Residence 6 Other (Specify) After this funeral 28e. Dete of injury (Manth Dey Year) Certification: 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending investigation 1 Naturel death. 1 ☐ Yes 2 ☐ No after death Director: 2 Accident filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, ferm/street, fectory, office building, etc. (Specify) 28f. Localion (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Mospital of within 24 hours a To the Funeral Completaly filled Certifying Physician: To the best of my knowledge deeth occurred at the time, dete end pleca, end due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and medical end piece. Medical 29e, Certifier 29b. Signature a d title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) H51280

Registrar

State

31. Dete filed (Month, Dey, Year) 21

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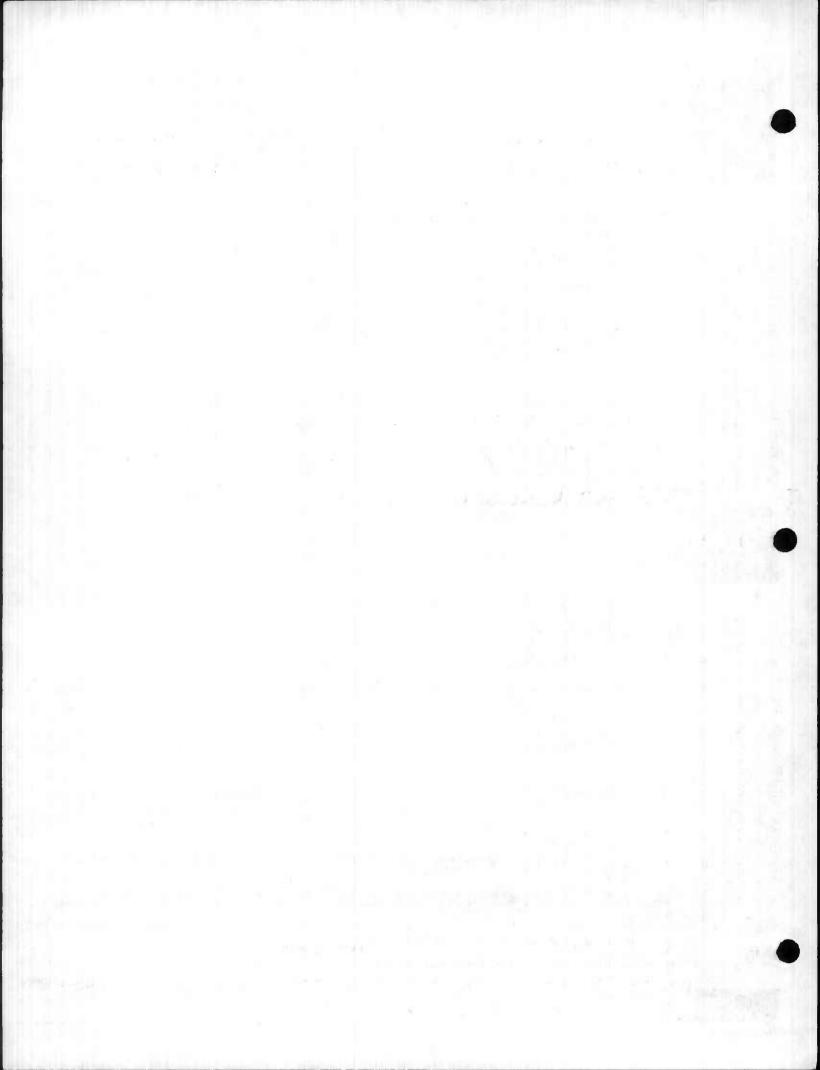
30. Name and address of person who completed cause of death (Item 234) (Type, Print)

34.50AC

13219 BXECCTUZ 32. Registrer's Signeture

PARK TRUDALER GREATHNEWN, UD 20874

Division of Vital Records, P.O. Box 68760.



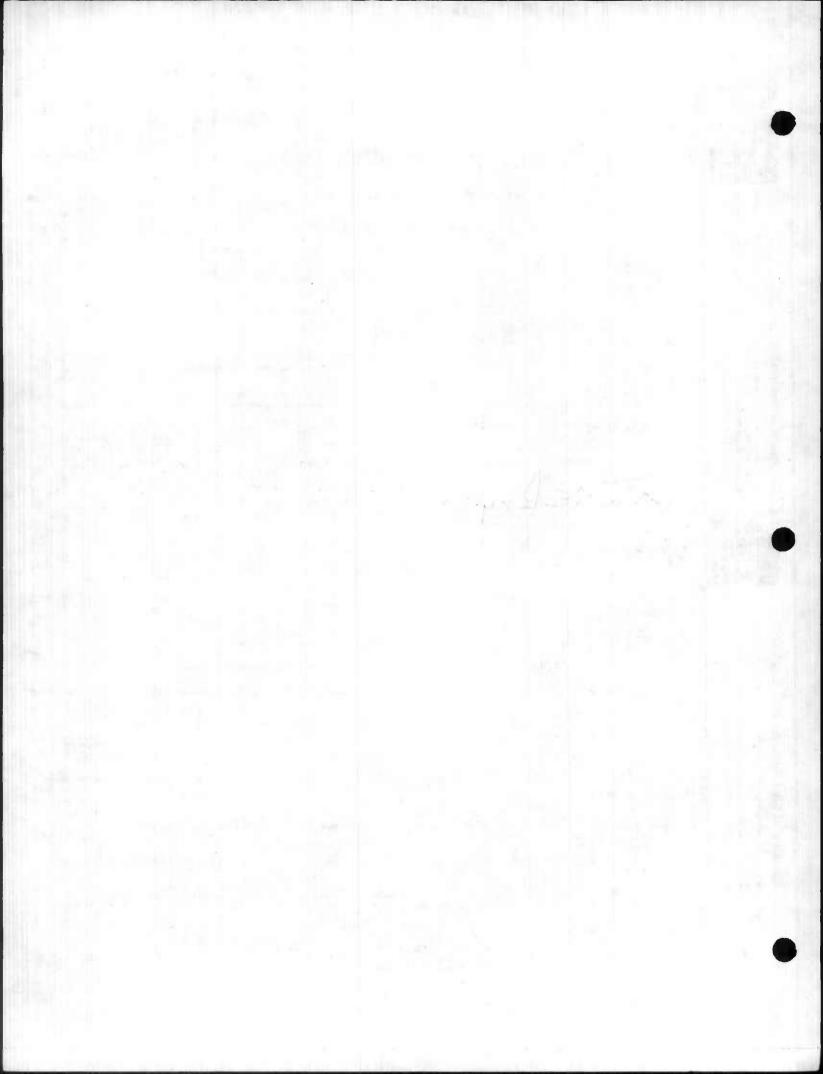
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Barbara R. Sexton July 19, 1999 9:15PM /Medical 4a Fscility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7028 Heatherhill Road Bethesda
If Under 24 Hrs.
Hours Min. Montgomery If Under 1 Ye 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 🕽 F Director 303-22-8408 Feb. 9, 1923 Indiana Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f ahow 1 ☐ Yes 2 No Directo Maryland Bethesda Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20817 7028 Heatherhill Road death Funeral United States 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Yeer or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus filed within 72 hours after 1 Never Married 2 ☐ Married 21215-0020 1 Yes 2 No Specify: Specify: by 3X Widowed 4 □ Divorced White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry I Hygiene. Engineering Consulting Elementary/Secondery (0-12) College (1-4or 5+) Partner 7 is marked other traumatic event, Baitimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Peges 1 and 2 should be nent of Health and Mental Paul F. Royster Nina Pease 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a ham 27 is r other tra Mary A. Sexton/Daughter 7028 Heatherhill Road, Bethesda, Maryland 20817 20b. Place of Disposition (Name of cometery, crematory or other place) July 21, 1999 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 포장 permit. Pege Department o Important: If 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland Pumphrey Funeral Home/ . 7557 Wisconsin Ave. Montgomery Crematorium, Inc.

22. Name and Address of Facility Robert A. 21, Signature of Funeral Service License Bethesda-Chevy Chase, Inc. 23a. Part1. Enter the disease, or complications that cauted the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one ceuse on each line. 20814-3501 Approximate Interval Betw Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Cancer of Larynx 8 Months Examiner Due to (or as a consequence of): Examiner that the death certificate be executed burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last pue Due to for es a consequence of) Box 68760. physician Physician/Medical the Due to (or ea a consequence of): 88 980 Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 0 23b. Did tobacco use contribute to the cause of death? 1) Yea 2 No 3 Probably 4 Unknown ۵ Records. þ The law requires 24b. Were autopsy tindings available prior to completion of ceuse of death? Completed 24a. Was an autopsy performed? paga 2 certificate t ☐ Yes 2 No t ☐ Yes 2K No Division of Vitai Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home SHResidence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28e. Date of Injury (Month, Dey Year) funeral 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Affer 1 Natural or Attending 5 Pending within 24 hours after death. To the Funeral Director: A investigation 1 Yes 2 No 2 Accident 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide Hospital edical tX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completely (Check only one) To the 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) wo 10 ule 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Catherine A. Picken, 20007-2197 M.D. 3800 Reservoir Road, N.W., Washington, D.C. 31. Date tiled (Month, Dey, Year) 32. Registrar's Signature State 2 1 1999

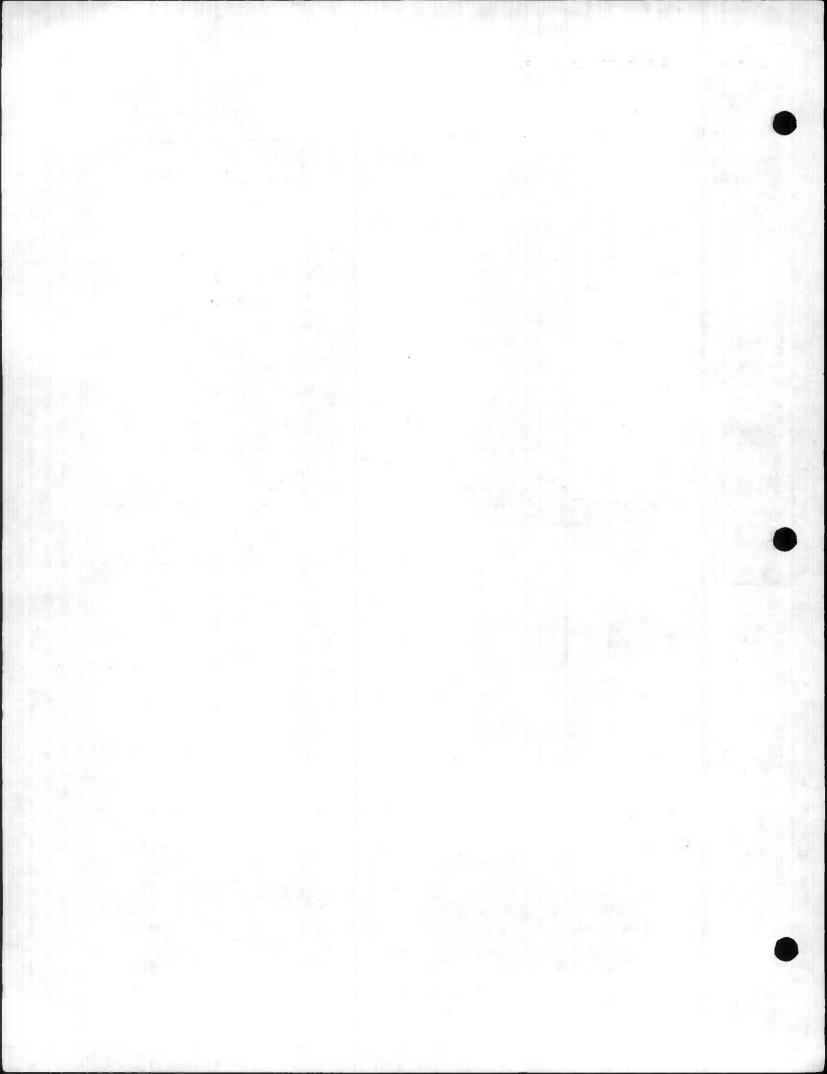
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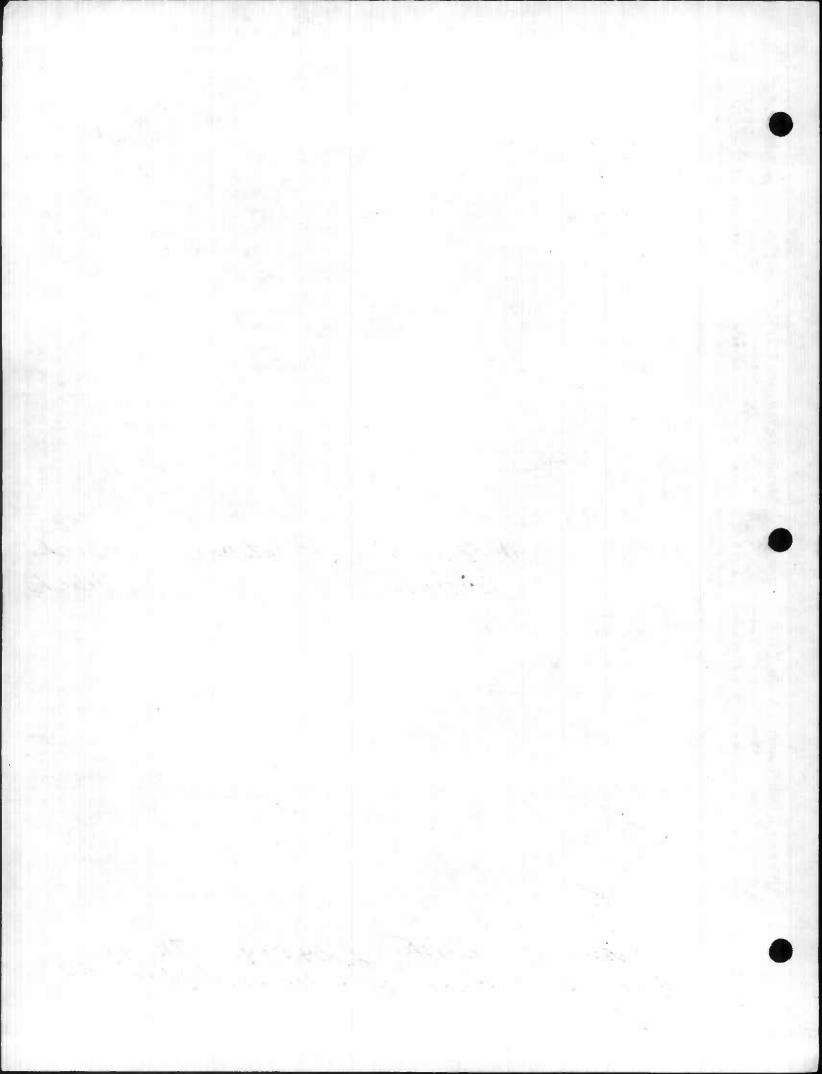
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/Medical		RNANDO SEQ				44 600 75	JULY	18, 19		759 PM
Examiner		o (If not institution, give				4b. City, Town, or I				
	5. Social Security		TRAUMA CENT	EK s. last birthday)	If Under 1 Year	BALTIMOF If Under 24 Hrs.		BALTI		State or Foreign
Funeral Director	577-80-	11	⊠M 2□F 46	Yrs.	Months Deys	Hours Min.	8. Date of Birth (Month, Day Nov. 2	7. Year)	Country) Nicara	State or Foreign
2	Usuel Residence	of Decedent					11.011	, 1,51		
A A A	10a. State	10b. County	10c. 0	City, Town or Lo	cation					side City Limits
or 28e-fa	Marylan	d Montgome	ry Sil	ver Spr						Yes 2 No
Die Die		Number			10f. Zip Code			10g. Citizen of	What Country?	
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or Henricher miner.	1 Never Me	erried 21 Married	Armed Forces? 1 ☐ Yes 2 ☑ No	0,0.	Yes, specify Cub	an, Mexican, Puert	o Rican, etc.)	Bla	ck, White, etc.	,
p y	3 🗆 Widowed	4 □ Divorced	If Yes, Give Year or Dates:	1	X Yes 2 □ No	Specify: Nic	caraguan	Specif	White	
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O O			2	Techn	ician			Electr		
8 8		e (First, Middle, Last)				18. Mother's Nan	ne (First, Middle,	Maiden Suman	ne)	
marked matic e		Sequeira		1		Maria T				
525	dilline	Name/Relationship (7				and Number or Ru				
If Health Item 27 other tr	Martha 20e. Method of D	Sequeira/		Place of Dispos	sition (Name of	Street,	Date		MD 2090 City or Town, S	
	1 Burial	2 Cremetion 3 🗆		The state of the s	natory or other pla	,	July 24			
Department of mysertant: If any injury or asse.		n 5 ☐ Other (Specify: Funeral Service Licen:			eaven Ce		1999	Silver	Spring,	MD
Departra Importa any inju	1	201	1200	Fr	ancis J.	Collins	Funeral	Home, I	nc.	
- 8	23a, Pert I, Ente	r the disease, or como	plications that caused the de one cause on each line.	ath. Do not ente	O Univer	sity Blvo	d. W., S	ilver S	pring,	MD 20901
hysician	shock, or h	eart leilure. List only o	one cause on each line.						Inter	oximete val Between et and Deeth
/Medical	Immediate Caus		Mutt. No	6,	ushat	11/2	10			
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n. After this certificate has been signed by the attending physicia funeral director, page 2 should be detached for use as the but lon: To Be Completed by Physician/Medical	Pert II. Other sig  25. Was case refexaminer?  XX Yes 2  27. Manner of De 1	rerred to medical No Path Solution of Could not be determined  1 Certifying Physical Examination of Could not be determined  1 Certifying Physical Examination of Could not be determined	Due to d	EP/Outpatien  28b. Time of Injury  7 4 5 4 home, farm, streity)  She cowledge, death action and/or inv	derlying cause given the state of the state	26. Place of Desher: 4 Nursing Hry at rk? Yes 2 SHO	23b. Did to 1 1 2 2 4 a. Was performent of the control of the cont	res 2 No  ne autopsy med?  res 2 No  ne)  lence 6 Ott  low injury occur  f 5 6 f  litreet and Numi  n, State) 6; f  run 9 M  aust(s) and m  date and place,  29d. Date signe  JULY 1:	24b. Were au available complete of death 1 Pres ner (Specify) med ber or Rural Roul mure Driv anner as stated, and due to the o	4 Unknown  topsy lindings prior to on of cause ?  2 No  te Number, 4 & Narkham  sause(s)



State of Maryland / Department of Health and Mental Hygiene

			Certificate of	Death	Re	g. No.	24421		
	1. Decedent's Neme (First, Middle, La	st)	*. *		2. Date of Death	1	3. Time of Death		
Physician /Medical	Lila M. Schaffe	nburg			Month July	21, 199			
Examiner	4e Facility Name (If not institution, give	e street and number)		4b. City, Town, or Lo	ocation of Death	4c. County of D	eath		
87	Manor Care Chev	y Chase		Chevy Cha		Montgon	nery		
Funeral Director	037-07-1311	7. Age (In yrs. Ia 1 M 2 S F 84	st birthday) If Under 1 Year Months Days		8. Date of Birth (Month, Day, March 17	9.1 7, 1915 01	Birthplace (State or Foreign Country) hio		
¥	Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Location	-			10d. Inside City Limits		
Se-f sho diffied a	Maryland Montgom		vy Chase	5 7		1 <b>∑</b> Yes 2 □ N			
That death with the Maryla r harms 23a or 28a-f sho kiner must be notified at Furneral Director	10e. Street end Number 5480 Wisconsin Av	enue #1014	10f. Zip Code	20815		tog. Citizen of What Country? United States			
Dy F	11. Meritel Stetus  1 Never Merried 2 Merried  3 Widowed 4 Divorced	t2. Was Decedent Ever in U,S Armed Forces? 1 12 Yes 2 No If Yes, Give Year or Dates: WWII	t3. Was Decedent of If Yes, specify Cub		ecify Yes or No- Rican, etc.)	t4. Race - A Black, W Specify:	merican Indian, Thite, etc. White		
5-0 72 ho 72 ho final	15. Decedent's Ed (Specify only highest gra		t6a. Decedent's Usual Occur (Give kind of work done	pation	ina	6b. Kind of Busine	ss/Industry		
D MM 0	Elementery/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retire	ed)			100		
d 21 High will Hygien dher the Mr. the		2	Homem			Own F	lome		
Maryland d 2 should be file th and Mental Hy T is marked oth treammetic event To Be (	t7. Father's Neme (First, Middle, Last	)		18. Mother's Name		laiden Surname)			
Tyla nould nould nould To	Lloyd Williams	1		Mary Mu	-	0: * 0:	7.0.11		
Man 12 st 1 st 1 st 1 st 1 st 1 st 1 st 1 st 1	19e. Informant's Neme/Relationship (		19b. Mailing Address (Stree						
- C	Dr. Carlos A. Schat					evy Chase			
altimore, mit. Pages 1 ar partment of Hea portent: if Item; r Injury or othe	1 ☐ Buriel 2 ☑ Cremation 3 ☐	Removal from Stete	metery, cremetory or other ple	July 22	1999				
Itim ritemen ritemit:	4 Donation 5 Other (Specification Service Liberature of Fupural Service Liberature of Se	Mon	Lgomery Cremat	-OLLUM, III	C.	ethesda,	Maryland Funeral Home/		
Denm Deper Impo	▶ V/A	M0112	D 1	hevy Chase	e, Inc.,	7557 Wis	consin		
	23e. Pent Angrine/disease or com shock, or heart failure List only	ane cause on each line.	Do not enter the mode of dy	ing, such es cerdiac	or respiratory arre	st,	Approximete Intervel Between		
Physician				20.1-	4 -		Onset and Death		
/Medical Examiner	Immediate Ceuse (Finel disease or condition resulting in death)	. moun	nonea,	101/191	era L		2 weeks		
p z			3 weeks						
68760, filicate be executed a physician and as the bunal-transit edical Examiner	Sequentially list conditions,	Due to (or a	as a consequence of):						
So so so so so so so so so so so so so so	Sequentially list conditions, if any, teeding to immediate cause. Enter Underlying Cause (Disease or injury	c							
68760, ficate be every physician is the burial E	that initieted events resulting in deeth) Last	Due to (or e	es a consequence of):						
- 5 0 E		d	,			_			
Box attendin for use									
P.O. BOX not the death cer dby the attendir letached for use PhysicianA	Pert II. Other algnificant conditions of	ontributing to death but not result	ting in the underlying ceuse gi	iven in Part I.			ute to the cause of death?		
that that y					1 U Ye	s 2LMNo 3L	Probably 4 Unknown		
Records, P.O. Box te law requires that the death cent has been signed by the attendin ge 2 should be detached for use impleted by Physiclan/N					24a. Wes ar		lb. Were autopsy findings available prior to completion of cause		
Re lav					1 □ Ye	s 200 No	of death? t □ Yes 2 □ No		
r Vitai I ysicien: The is certificate director, pag To Be Co	25. Was case referred to medical axaminer?			26. Place of Deat	h (Check only one	9)			
- 5 m	1 Yes 2 240	Hospitel: 1 ☐ Inpatient 2 ☐ E	R/Outpatient 3□ DOA Ot	ther: 4 12 Nursing Ho	me 5 Reside	nce 6 Other (5	Specify)		
VISION O Attending Ph r death. ector: After thi by the funeral	27. Menner of Death  1 Naturel 5 Pending 2 Accident investigation	(Month, Day Year)	28b. Time of Injury M 28c. Injury M	ury at ork? ☐ Yes 2 ☐ No	28d. Describe ho	w injury occurred			
Division of below the state of	3 Suicide 6 Could not be determined		ne, ferm, street, factory, office			81. Location (Street and Number or Rural Routa Number, City or Town, Stete)			
Div To the Hospital or A within 24 hours after To the Funeral Dire comptately filled in b Medical Certi		ysician: To the best of my knowl niner: On the basis of examinetic							
within on the comple	29b. Signature and silier of certifier.	11	29c. Licen	ise number	29	d. Dete signed (M	onth, Day, Year)		
m × m 0	) (hard	Hostor	10 D	Del 17	,	76,10	O		
10+1	30. Name and address of person who	completed cause of death (Item 2	23a) (Type, Print)	17117	-1	1-114	2./		
	Jimes &	TESTER MA	5530	Wese A	1. Cher	ymas	e ma		
State Registrar	3t. Date filed (Month, Dey, Year)  JUL 23 199	32. Registrer's Signetu	B. Snaw	ise number  94179  Wese Au					
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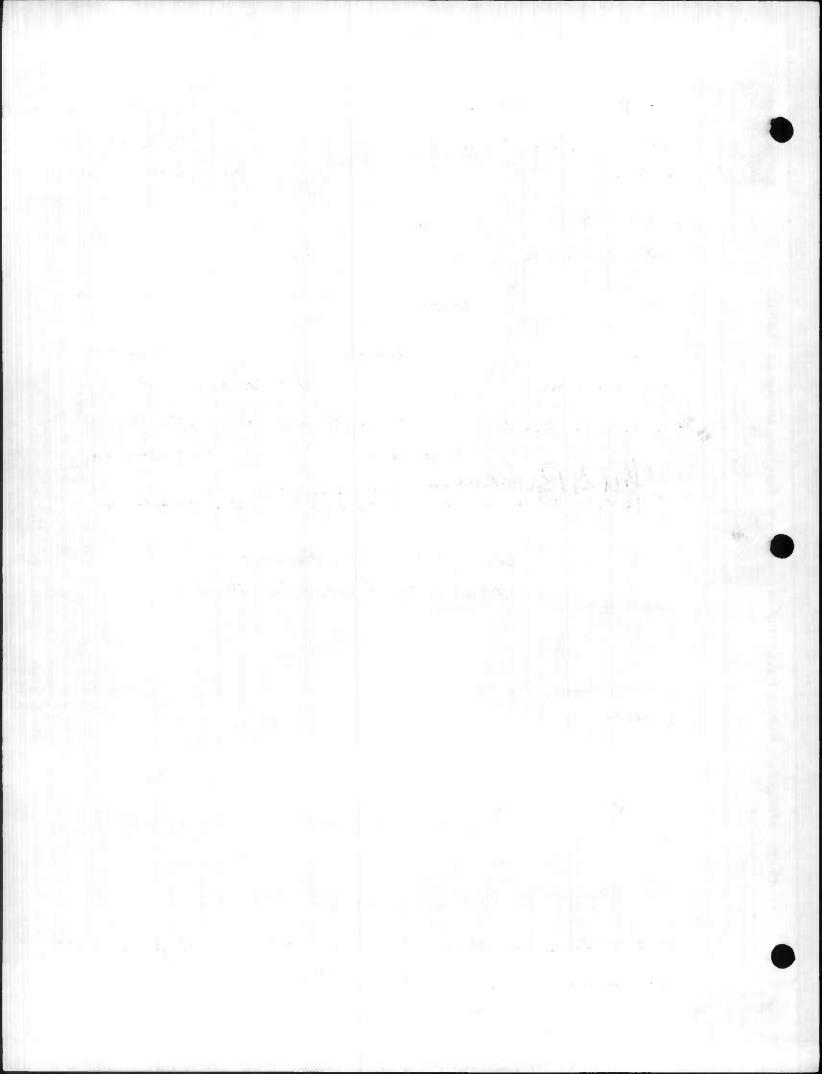
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedant's Nama (First, Middle, Last) 2. Data of Death Day Month **Physician** ALBERT CARL July 20, 1999 SCHEUNGRAB, SR. 8:45 AM /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner Prince George's Southern Maryland Hospital Clinton If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) If Undar 1 Yaar 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 6. Sax **Funeral** 1 XM 2 □ F Months Days Yrs 215-12-2952 July 6, 81 1918 Maryland Director Usual Rasidance of Deceden the Meryland 10a Stata 10b County 10c. City. Town or Location 10d. Insida City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yas X区No Director Maryland Charles Waldorf 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 13030 Shlagel Road 20601 USA permit. Pages 1 and 2 should be filed within 72 hours after deeth a Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any injury or other traumatic avant Funeral 12. Was Decedant Evar in U.S. Armed Forcas? 1 (X)Yas 2 □ No If Yas, Giva Yaar or Dates: 1942-45 14. Race - Amarican Indian, Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) Black, Whita, atc 1 □ Navar Married 2 □ Married altimore, Maryland 21215-0020 1 ☐ Yas 2 XNo Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedant's Education (Spacify only highast grada complated) Elementery/Secondary (0-12) Collega (1-4or 5+) Mechanic Automotive 18. Mothar's Nama (First, Middla, Maidan Sumema) 17. Fathar's Nama (First, Middla, Last) Joseph Scheungrab Rosie Schromgurselloge 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 10557 Bramley Court, Waldorf, MD 20603 <u> Marie A. Clark - Daughter</u> 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata
4 ☐ Donation 5 ☐ Other (Span) Huntt Crematory 7-21-99 Waldorf, MD 5 □Other (Spa al Sphipe I 22. Nama and Addrass of Facility Huntt Funeral Home, Inc. Part. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intarval Between Onsat and Death **Physician** Immediata Causa (Final disaasa or condition resulting in death) /Medical ASCALON Examiner Examiner Men oscientre physician end s the buriel-transit that the deeth certificate be executed Sequantially list conditions, if any, leading to immadiata causa. Enter Underlying Causa (Disaasa or injury thet initiated events rasulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of) use as t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uss contributs to the causs of death? the signed by the 3 Probably 4 Unknown 1 ☐ Yss 2 ☐ No 1 Abeta þ 24b. Ware autopsy findings available prior to Completed 24a. Was an autopsy parformed? complation of causa of death? After this certificate has 2 No 1 □ Yas 2 □ No 25. Was case rafarred to medical axaminar? Be 26. Place of Death (Check only one) 1 Yas 2 No Hospital: Othar: 4 ☐ Nursing Homa 5 ☐ Rasidanca 6 ☐ Othar (Specify) 2 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Mannar of Death 12 Naturel 2 Accident 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury et Work? Certification: i or Attending P after death. 5 Panding investigation 1 ☐ Yes 2 ☐ No 6 Could not be datermined 3 Sulcida 28a. Place of Injury - At home, farm, streat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 4 Homicida To the Hospital e within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at tha time, data and place, end due to the cause(s) and mannar as stated.

2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and mannar stated. 29a. Certifier Medical (Check only one) 29d, Data signed (Month, Dav. Year) 29b, Signatura and titla of certifier 29c. Licansa number elder mo 30. Nama end addrass of person who complated causa of death (Itam 23a) (Type, Print) 177/d50A 31. Data filed (Month, Day, 32. Registrar's Signatura State 23 1999 Registrar JUL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ( Certificate of Death Reg. No. 3. Tima of Deeth 1. Decedent's Nama (First, Middla, Last) 2. Date of Death Month Day **Physician** John Harold Sprinkle, Sr. July 14, 1999 10:00 a.m /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Name (If not institution, give streat and number) **Examiner** 10618 Perkins Hill Road (Residence) Chestertown Kent If Undar 24 Hrs. 8. Data of Birth
Hours Min. (Month, Day Year) If Undar 1 Yaar Birthplaca (Stata or Foraign Country) 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) **Funeral** Months XXM 2DF Days 236-12-7398 81 February 7, 1918 West Virginia Director Usual Rasidance of Decedent the Marylend 10a. Stata 10c. City. Town or Location 10d. Insida City Limits 10b. County r than "naturel", or itema 23a or 28a-f show the Hedical Examiner must be notified at 1 Yes 2 No Directo Maryland Kent Chestertown 10e. Street and Number 10f. Zlp Coda 10a. Citizen of Whet Country? with 10618 Perkins Hill Road 21620 USA Funeral deeth 12. Was Dacedant Ever in U,S. Armed Forcas? 1/2 Yes 2 ☐ No If Yas, Give 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - Amaricen Indian, Black White atc. Peges 1 end 2 should be filed within 72 hours effer nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "naturel", or ite 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2X No Specify: White Specify: A 3 ☐ Widowed 4 ☐ Divorced Yaar or Detas: 1943-1945 Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grade completed) 16b. Kind of Businass/Industry Collaga (1-4or 5+) Elamantary/Secondary (0-12) 12 6 Architect Building 17. Fether's Neme (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) Be John Ferdinand Sprinkle Florence Cage 19b. Mailing Addrass (Street and Numbar or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Neme/Ralationship (Type, Pnint) Jane Sprinkle/Wife 10618 Perkins Hill Road, Chestertown, MD 21620 other 20b. Place of Disposition (Nama of cematery, cramatory or other place) 20c. Location - City or Town, State 20e. Mathod of Disposition Data 8 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from Stete permit. Pege Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Christ I.U. Cemetery 7/17/99 Chestertown, Maryland 21. Signature of Euneral Service Licenses 22. Neme and Addrass of Facility Pellows, Helfenbein & Newnam Funeral Home, P.A. 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest. Approximete Intervel Batween Onset end Death Physician /Medical Immediate Ceuse (Finel COPP 10 485 diseese or condition rasulting in death) Examiner Due to (or es a consequance of): Examiner that the death certificate be executed Sequantially list conditions, if eny, laading to immadiata ceuse. Enter Underlying Cause (Diseasa or Injury that initiated evants rasulting in death) Last pue the buriel-tran Dua to (or as e consaquence of): P.O. Box 68760. ettending physician for use es the burie Physician/Medical Dua to (or as a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by t should be detach 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No þ 24b. Were autopsy findings svallable prior to completion of cause of deeth? 24a. Wes an autopsy performed? Completed 1 ☐ Yas 2 ☐ No 1 ☐ Yas 2 ☐ No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Was cesa rafarred to medicel Be 26. Placa of Death (Check only ona) axaminar? Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 8 Other (Specify) P 1 Yas 2 1 No 27. Menne of Deeth 28a. Data of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred 28b. Tima of Certification: 1 Naturel 5 Panding invastigation injury 1 ☐ Yas 2 ☐ No 2 Accident 3 Suicida 6 ☐ Could not be datarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At home, farm, streat, factory, offica building, atc. (Specify) 4 \ Homicida

1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and mennar as stated.
2 Medical Examiner: On the basis of axamination end/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) mannar stated.

MO

29c. Licansa number

DS6054

29d. Deta signed (Month, Day, Year)

120 SPEEN AD Chutchin Mz

State Registrar

edical

29a, Cartifian

29b. Signature and title of

ponicle

31. Date filed (Month, Day, Year)

sertifier

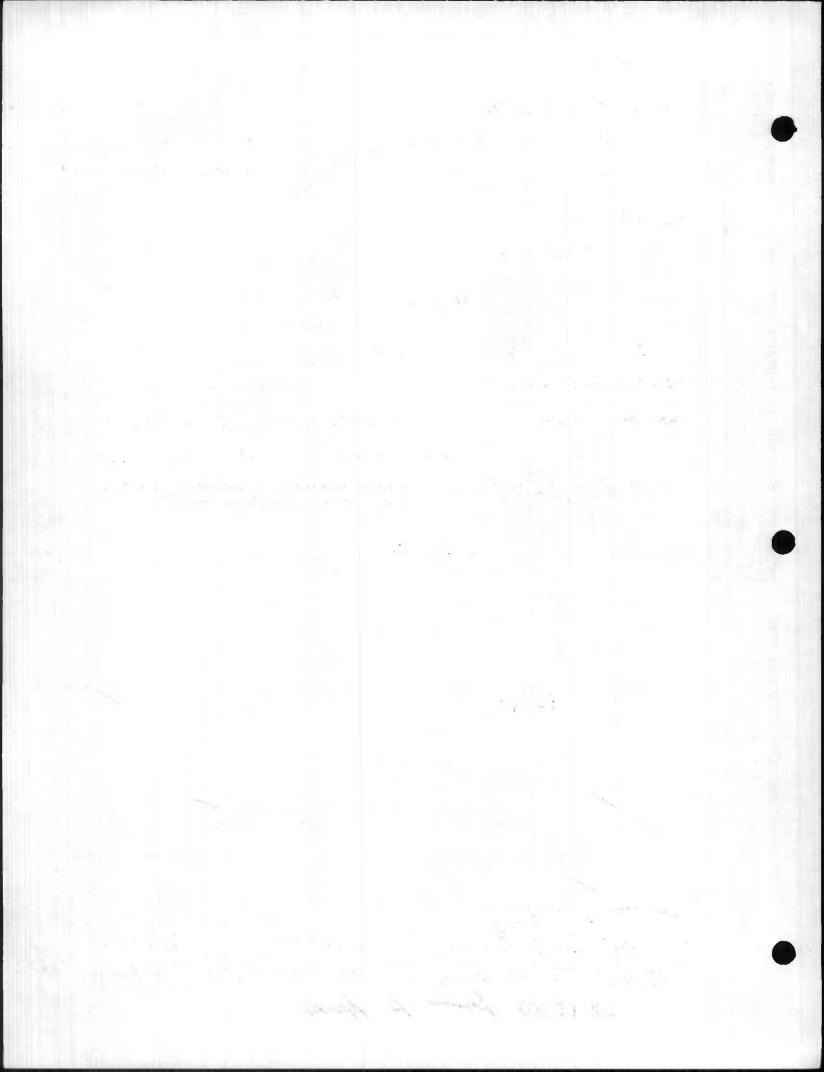
JUL 1 5 1999

30. Name and address of person who complated cause of death (Item 23e) (Type, Print)

CI SHONDADW

32. Registrar's Signatura

Eelit



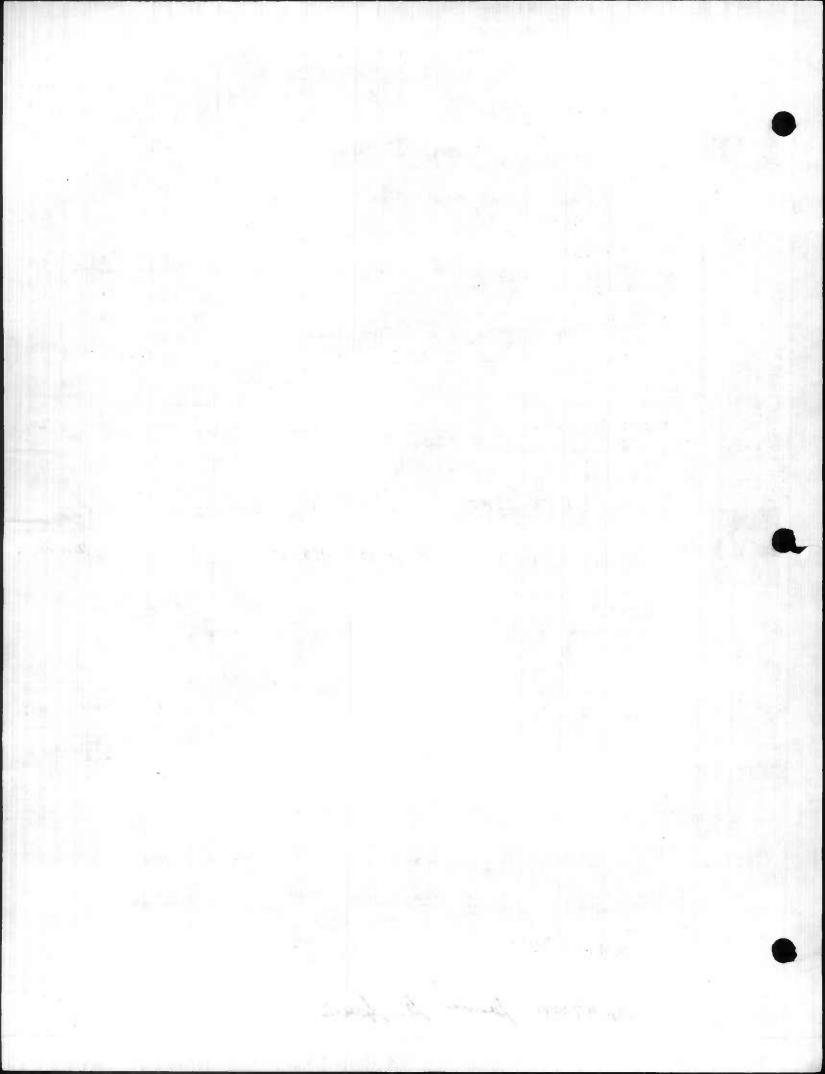
State of Maryland / Department of Health and Mental Hygiene (1) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Clifton Izer Stanford July 21 1999 9:50PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner The Memorial Hospital Talbot Easton If Under 1 Year If Under 24 Hrs.

Months Devs Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 100 M 2□ F Days 63 Director 217-30-8109 11/5/35 Maryland Usual Residence of Decedent the Meryland 10b. County 10c. City. Town or Location r than "natural", or forms 23s or 28s-f ahow the Medical Exempler must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Director Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pernit. Pages 1 and 2 should be filled within 72 hours after death with I Department of Health and Mental Hygiene. Inportant: if item 27 is marked other than "natural", or home 23s or 2 any injury or other traumatic event, the Medical Examinar must be an once. 6805 Harmony Road 21629 United States Funeral 11 Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Yes, Give Year or Dates: 1 Never Married XX Merried anford clifton althore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Black Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usuel Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Factory Worker Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 8 Clifton Johnson Dorothy Holmes 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 4280 Federalsburg High Federalsburg MD 21632 of Disposition (Name of Dete 20c. Location - City or Town, State Dorothy Brooks/Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 1 Burial 2 Cremation 3 Removel from Stete Federal Hill Cemetery 7/26 Federalsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility Framptom-Hawkins-Eskow Funeral 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as carolac or respiratory arrest. 9 3 Approximete Intervel Between Onset and Deeth **Physician** Metastatic germ cell terror 6 aurilles /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner that the death certificate be executed ettending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760. Physician/Medical Due to (or es a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? Cenhosis of lever 1 Yea 2 No 3 Probably 4 Unknown Records. þ The lew requires 24b. Were autopsy findings sveilable prior to completion of cause of death? 24a. Wes an autopsy performed? Completed page 2 s this certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 21 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 C Natural 28d. Describe how injury occurred 28b. Time of Certification: 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? After in 24 hours after death.
the Funeral Director: Aft 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 ☐ Homicide To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signeture and title of certifier 29c. License numba 29d. Date signed (Month, Day, Year) Words 23/99 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) JUL 2 7 1999 32. Registrar's Signature State

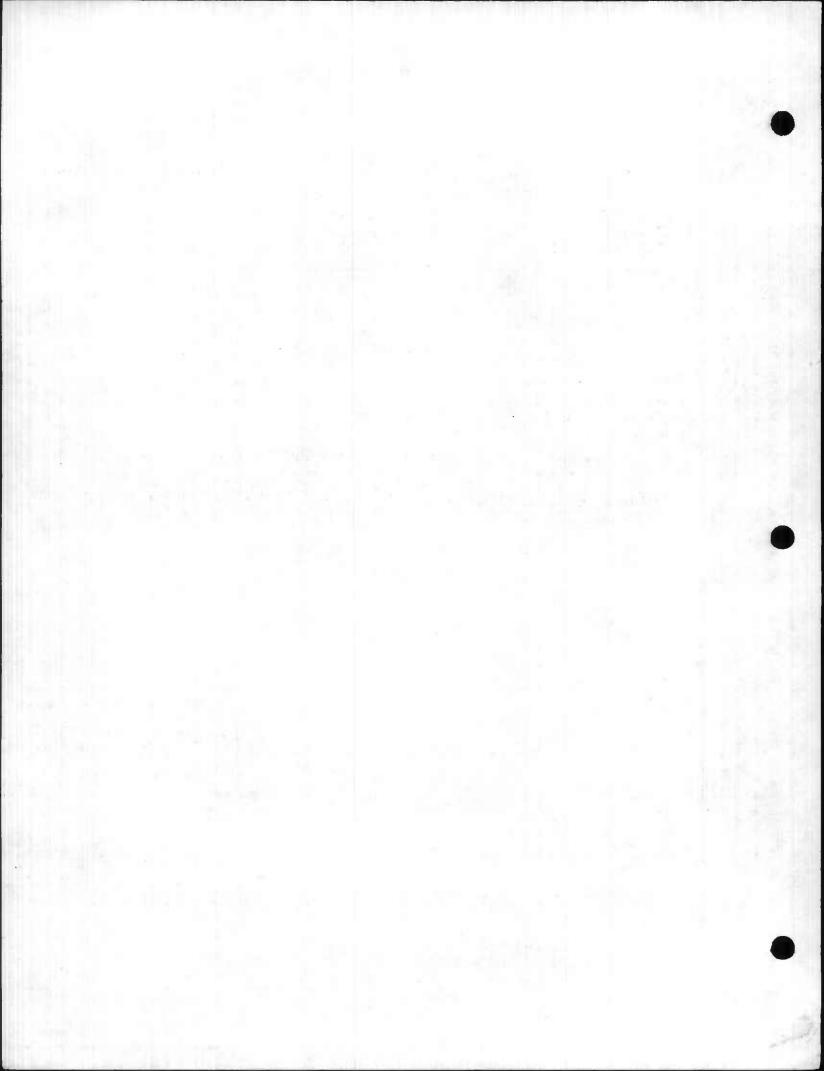
**DHMH 16 Rev 6/95** 

Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** MICHAEL LOUIS 0947 JUC-1994 17 /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Spring SICUM Montaburer HOLY CLOSS HOSPITAL If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Feb. 6, 1947 5. Social Security Number If Under 1 Year Birthplece (Stete or Foreign Country) 6 Sev 7. Age (In yrs. last birthdey) **Funeral** Months Days Hours 100 M 2□ F 216-50-5742 52 Yrs. Pennsylvania **Director** Usuel Residence of Decedent 10a. Sfate 10b. County 10c. City, Town or Location 10d. Inside City Limits show 1 Yes 2 No Maryland Montgomery Director Silver Spring 28a-11 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 13212 Trumpet Place 20904 United States Nerna 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2)() No 14. Rece - American Indien, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 natural, or 1 Yes 2 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene important if them 27 is marked other then in any injury or other traumatic Elementery/Secondery (0-12) College (1-4or 5+) Security Consultant U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Louis Albert Tanquay Magdalene Spicer 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lori J. Tanguay (wife) same as #10 20b. Plece of Disposition (Neme of cametery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial ②Command 3 ☐ Removal from State Metropolitan Crematory 7/22/1999 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signafore of Funeral Service Lin 22. Neme and Address of Facility
Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705 23a. Pert1. Enter the disease, or compile tods that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart feiture. List only one a use on each line. Approximate Interval Between Onset and Deeth Physician Immediate Cause (Final disease or condition resulting in death) PULMONARY ARTERY TAXOMED EMBOLISM /Medical Examiner Due to (or as a consequence of): Examiner physician and s the buriel-transit be executed Sequentially list conditions, if any, leading to immediate cause. Enfer Underlying Cause (Disease or Injury that initieted events resulting In death) Last Due to (or as e consequenca of): Box 68760 Physician/Medical Due to (or as a consequence of) Attending | P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? by the 1 Yes 2 No 3 Probably 4 Unknown MORUSTASORH signed b Records, ð 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was en eutopsy Completed peed page 2 No 1 ☐ Yes 3 No 1 Yes certificate Division of Vital Hospital or Attanding Physician:
 24 hours after death.
 Funeral Director: After this certifical letely filled in by the funeral director; 25. Was casa referred to medical Be 26. Placa of Deeth (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) Medical Certification: 27. Menper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Netural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29e. Certifin 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated.

[See Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner steted. To the within 2 To the 29d. Dete signed (Month, Day, Year) 29b. Signati re and title of certifier 29c. License number 015236 JUY 17, 1999 m. 1. 30. Nama and address of person who completed cause of deeth (Item 23a) (Type, Print) ROCKVILLE PIKE, POCKVILLE, MO 2. MAROUS, MO. 11/25 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State oaks 20 Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Year Month **Physician** WILLA 21, 1:00 AM M. TERRY JULY 1999 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 6300 OSAGE ST. BERWYN HEIGHTS PRINCE GEORGES If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) Dete of Birth (Month, Day, Year) Birthplaca (Stete or Foreign Country) **Funeral** Deys 1□ M 2♥ F 116-03-3229 Usual Residance of Decedent Yrs. **Director** 8, ALABAMA 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show neturel, or items 23s or 28s-f show deal Examiner must be notified at 1 X Yes 2 No Director PRINCE GEORGES MT. RAINIER 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3001 QUEENS CHAPEL RD. #304 20712 U.S.A. death Funeral 12. Wes Decedent Evar in U,S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 11. Merital Stetus permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or iten any injury or other treumatic event, the Medical Exemplance. 1 Nevar Married 2 Married 1 ☐ Yes 2 (No If Yes, Give Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ 3 MWidowed 4 □ Divorced BLACK Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) 12 CATER/DOMESTIC ENGINEER PRIVATE HOMES 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be 2 HOMER DOZIER LEILA TENNY THRASHER 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) STEPHANIE TERRY/DAUGHTER OSAGE ST., BERWYN HEIGHTS, MD. 20740 20b. Place of Disposition (Name of cematary, crametory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) CHAMBERS CREMATORY RIVERDALE, MD. 21. Signeture of Funeral Servica Licersee 22. Nema and Address of Fecility MOO091 CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failura. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel END STAGE CONGESTIVE HEART FAILURE 30 DAYS disease or condition resulting in death) **Examiner** Due to (or as a consequence of): Examiner sloian and bunal-transit that the death certificats be asscuted Sequentielly list conditions, if any, leeding to immediate cause. Enter Undarlying Cause (Diseasa or injury that initiated events resulting in deeth) Last Due to (or es a consequence of): physician s the buria 68760. Physician/Medical Due to (or as a consequence of): 88 Box ( P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 M Unknown PERIPHERAL VASCULAR DISEASE signed t Records. þ The law requires 24b. Were autopsy findings available prior to 24e. Wes en eutopsy performed? Completed completion of cause of death? 1 Yas 2 No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) COUSINS Hospitel: Other: 4 Nursing Home 5 Residence 6 20ther (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA HOME 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury st Work? 28d. Describe how injury occurred 28b. Time of 1 Naturel 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) à 4 ☐ Homicide To the Funeral D 24 hours a 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred et the time, date end pieca, and due to the cause(s) and menner steted. edical 29a, Certifier To the To the To the 29b. Signature and title of penillier 29c. License number 29d. Dete signed (Month, Day, Year) as Ecuosa D26873 JULY 21, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SANZARO, 5804 BALTIMORE AVE., HYATTSVILLE, MD. KATHERINE M.D. 31. Dete filed (Month, Day, Year) 32. Registrar's Signeture 23 1999 Registrar

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State Registrar

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is merked other than "natural", or items 23a or 28a-f show any injury or other traumatic avant, the Medical Exercise must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

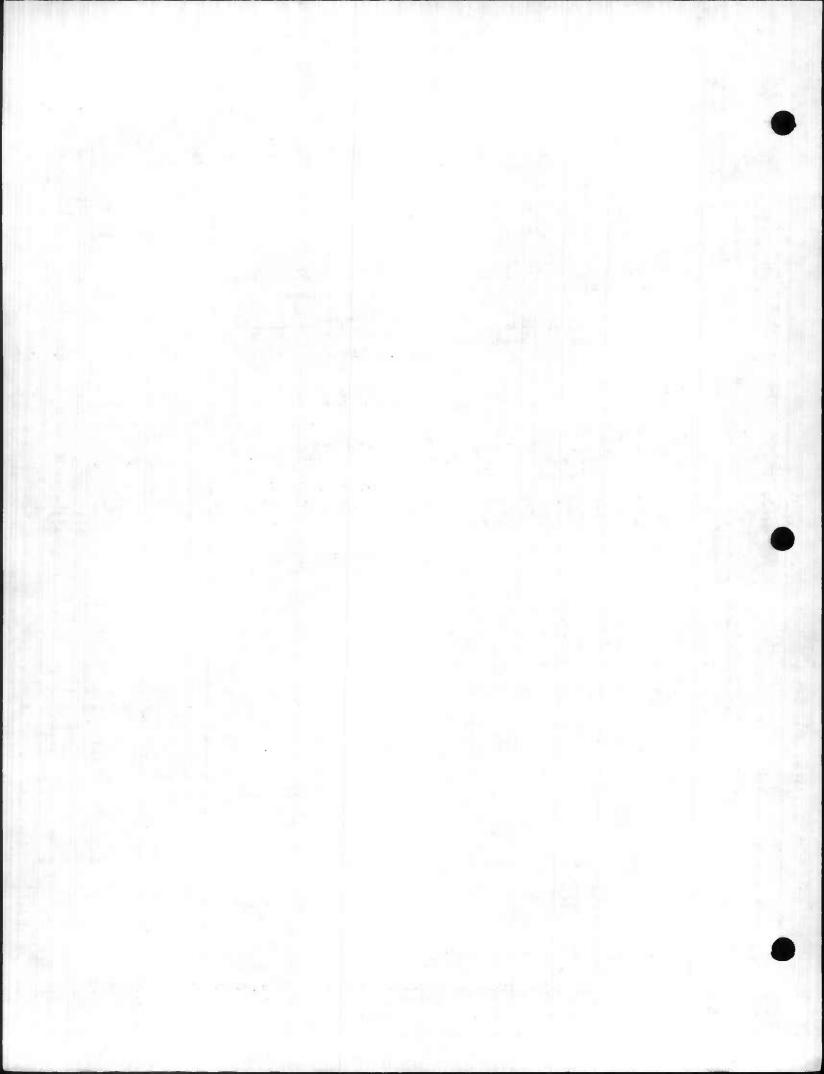
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

I'M MENMAN, Marie

Baltimore, Maryland 21215-0020

7-1299



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend #26, 7/23/99, BMW, Montq. Co 2 Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) ENTO 19 ga **Physician** LUBB 28 0715 twe 19 /Medicat 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1712 BRISBANG STOLDET SILVE SPRING MONTGOMBURY 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** 1₩ M 2□F Months Days Hours Min Yrs. Director 209-20-5661 69 March 17, 1930 Pennsylvania Usual Residence of Decedent the Merylend show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours efter death with the Meryle Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23a or 28a-f show any Injury or other treumatic event, if a Medical Exercise must be notified a page. 1 ☐ Yes 2 No Directo Pennsylvania Montgomery Glenside 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 543 Edgley Avenue 19038 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Bleck, White, etc. 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: WW II 1 Never Married 2 N Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Banker Banking 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be Ear1 Treese Helen Pieghtal 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 543 Edgley Avenue (wife) Glenside, Pennsylvania 19038 Mary Louise Treese 20b. Place of Disposition (Name of cametery, cremetory or other place) July 20c. Location - City or Town, Stata 20a. Method of Disposition 24 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1999 Patrick's Cemetery Hockessin, Delaware 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Francis J. Collins Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory errest, shock, or heart failure. List only one ceuse on each line. MD 20901 Approximate Interval Between Onset and Death **Physician** Immediete Cause (Finel diseese or condition resulting in death) /Medical ARTENIOSCUMPTIC CHILD DUBLEUUBA Examiner Due to (or as a consequenca of): Examiner physician and the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): certificate be execu Box 68760, Physician/Medical Due to (or es e consequence of): 88 nse nse Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? o 1 Yes 2 No 3 Probably 4 Unknown ے HABERTENTION þ Division of Vital Records, 24a. Was an autopsy performed? 24b. Were eutopsy findings available prior to Completed completion of cause of deeth? 188 1 Yes 2 No 1 ☐ Yes 2N No or Attending Physician: funeral director, 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 3 Residence 8 Mother (Specify) Hospital: Yes 2□ No To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 Devetural 5 Pending after death. 1 Yes 2 No 2 ☐ Accident Investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) filled in by 4 ☐ Homicide To the Hospital o within 24 hours af To the Funeral D completely filled i 29a. Certifie 1 Craftifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) and manner es steted. Medical

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State Registrar

and title of certifier

one)

29b. Signetu

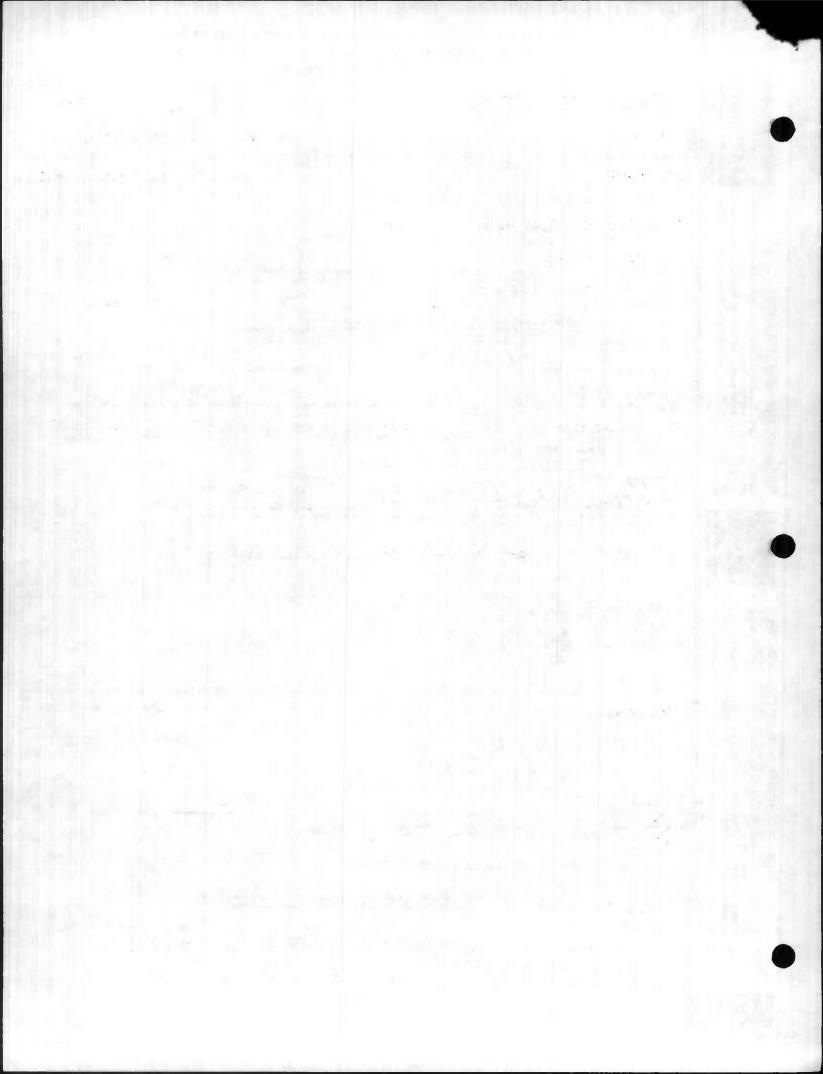
30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) PIKE (BOCKU) US 100 32. Pegistrer's Signature

Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

015236

29d. Date signed (Month, Dey, Year)

1991, 1999 Yest



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) July **Physician** Stanley Tretick 19 1999 1:55 P.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Wilson Health Care Center Gaithersburg Montgomery | If Under 1 Year | If Under 24 Hrs. | 6. Date of Birth (Months Days Hours Min. | 6. Date of Birth (Month, Day, Year) | 1. | 5. Social Security Number 7. Age (In yrs. lest birthdey) 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Months 578-16-1406 Yrs. 1921 77 Maryland Director Usuai Residence of Decedent with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Show 7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examinar must be notified at MD Montgomery Gaithersburg 1 ☐ Yes 2 1 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 301 Russell Avenue 20877 U. S. A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 to Yes 2 □ No If Yes, Give Yeer or Dates: 14. Raca - American Indian, 11 Maritel Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after or nent of Health and Mental Hygiene.
ntt: If Itam 27 is marked other than "natural; or Item 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: WW II White Specify: by 3 ☐ Widowed 4 K Divorced Hygiene. other than "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) Elementary/Secondary (0-12) Photographer Journalism 12 18. Mother's Name (First, Middle, Malden Sumame) 17. Father's Name (First, Middle, Last) William Tretick Sophia Rosenberg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kitty Kelley - Friend 3037 Dumbarton St. N.W. Washington, D. C. or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burlal 2 IX Cremation 3 ☐ Removal from State permit. Page Department o Important: If I 7/23/99 Falls Church, Virginia National Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons Horntaker 5130 Wisconsin Ave. NW Washington, D.C. 20016 ε. Komas 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, ahock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Days theumonia disease or condition resulting in death) Examiner Due to (or es a consequence of): Examiner requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Diseese or injury that initiated events resulting in death) Last and burial-tran Due to (or as e consequenca of): P.O. Box 68760. physician Physician/Medical the Due to (or es e consequenca of): 50 USB for the t Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? detach signed by 1 Yes 2 10 3 Probably 4 Unknown Dementia Records, þ 24b. Were autopsy findings eveilable prior to completion of cause of death? Cerebral Vascular accident Completed 24a. Was an autopsy page 2 certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completaly filled in by the funeral director, 25. Was case referred to medical Be 26. Piece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 10 Certification: 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 12 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated.

27 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. edical 29a. Certifier (Chec 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature an 30. Neme and address of person who completed cause of death (Item 23e) (Type, Print) 9410 Old Georgetown Road, Bethesda, Maryland 20814 Schulman Gel MD 31. Bate filed (Month, Day, Year) 32. Registrar's Signature State 23 1999 Registrar

**DHMH 16 Rev 6/95** 

AND THE CHARLES OF THE PERSON

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Catherine Month 12 HOMPSON Marie /Medical 00 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital H Under 1 Yaar If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, orchester General Dorchester 5. Social Sacurity Number 6. Sax 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10 M 210 F 214-36-7227 60 1939 Maryland Yrs. Director Feb.26. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits event, the Medical Examiner must be notified at 1 Ves 2 No Director ambridge Herrie 23a or 28a-f Dorchester 10e. Street and Number 10g. Citizen of What Country? 305 Road Rusader 26 5 /4

14. Race - American Indian, Black, White, etc. 161 Funeral 12. Was Decedant Evar in U,S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) Baltimore, Maryland 21215-0020 

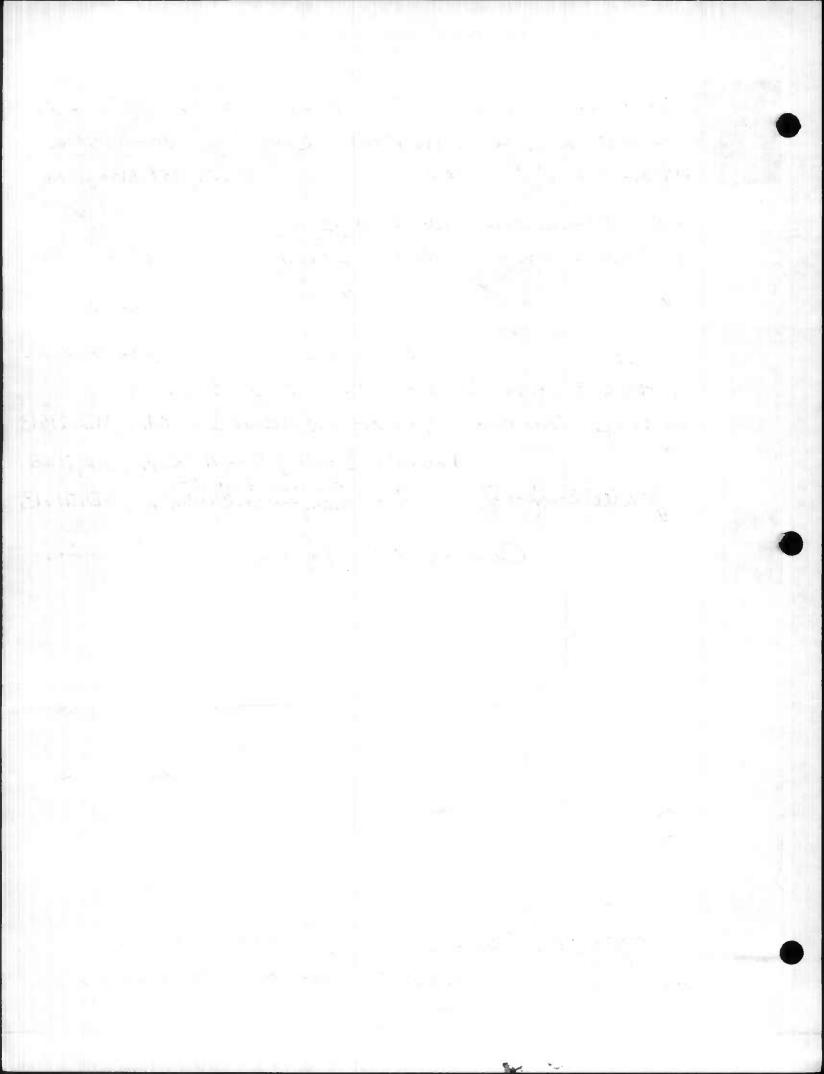
✓ 1 Never Married 2 Married ò 1□ Yes 212 No þ 3 Widowed 4 □ Divorced f Yes, Give Year or Datas: Black Completed 15. Decedent's Education (Specify only highest grade complated) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 72 and Mental Hygiene.
7 is marked other than "no Elementary/Secondary (0-12) College (1-4or 5+) Private Residence Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Sumama) Be COPPER. homas P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an Item 27 Kinner 20b. Place of Disposition (Name of cemetery, crematory or other place) Avenue Cambridge MD, 21613 DesiRee 20a. Method of Disposition 20c. Location City or Town, State Date Department of Important: If it any injury or o snos. 1 Burlal 2 □ Cremation 3 □ Removal from State Paradise Cemetery 7/22/99 TRappe, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Henry Funeral Home P.A 22. Name and Address of Facility 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Approximate Physician /Medical Immediate Cause (Final disease or condition resulting In death) 2 hrs Examiner Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): the attending physician and Division of Vital Records, P.O. Box 68760. that initiated events resulting in death) Last Dua to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Ninknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 20 No 1 Yes ANO or Attending Physician: 25. Was case referred to medical examiner?

2 □ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 7 1 ☐ Inpatient 2 FR/Outpatient 3 ☐ DOA 5 ☐ Rasidence 6 ☐ Other (Specify) this funeral 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After t Certification: Natural 5 Pending Investigation ours after death. 1 Yes 2 🗆 No 2 Accidant 6 Could not be 3 Sulcida 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicide the Hospital within 24 hours a To the Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

\*\*Ededical Examinar: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and andress of erson who completed cause of death (Item 23a) (Type, Print) 302 Coll 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar



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State of Maryland / Department of Health and Mental Hygiene	9	9	1
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lar	s 1 and 2 should t Health and Mer tem 27 is marks other traumatic	19a. Informant's Name/Relationship	(Type, Print)	19b. Ma	iling Address (Street	and Number	or Rural Route Numi	ber, City or Town,	State, Zip	Code)		
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Ore	of Hear	20a. Method of Disposition		Ob. Place of Dis cemetery, cr	position (Name of remetory or other ple	ce)	Dale	20c. Location	City or Tov	vn, Stete		
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Baltimore,	permit. Page Department o Important: If eny Injury or page.	21. Signalure of Funeral Service Licensee 22. Name and Address of Fecility										
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	Within To the Comp	29b. Signature and title of certifier			29c. Licens	se number	d) 1 5 12 1	29d. Date signe	d (Month, L	Day, Year)		
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	>	30. Name and address of person who	completed cause of death	(Item 23a) (Type		0 1 1				20910		
			. KHALID,			TON S	T. #700,	SILVE	R SP			
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	Division of Vital Records, P.O or Attending Physician: The law requires that the after death.  Director: After this certificate has been signed by the funeral director, page 2 should be deteched in by the funeral director, page 2 should be deteched in by the funeral director, page 2 should be deteched in by the funeral director, page 2 should be deteched in by the funeral director, page 2 should be deteched in by the funeral director.									24a. Was perfo	an autopsy rmed?	avai	ra autopsy findings lleble prior to aplation of cause aeth?
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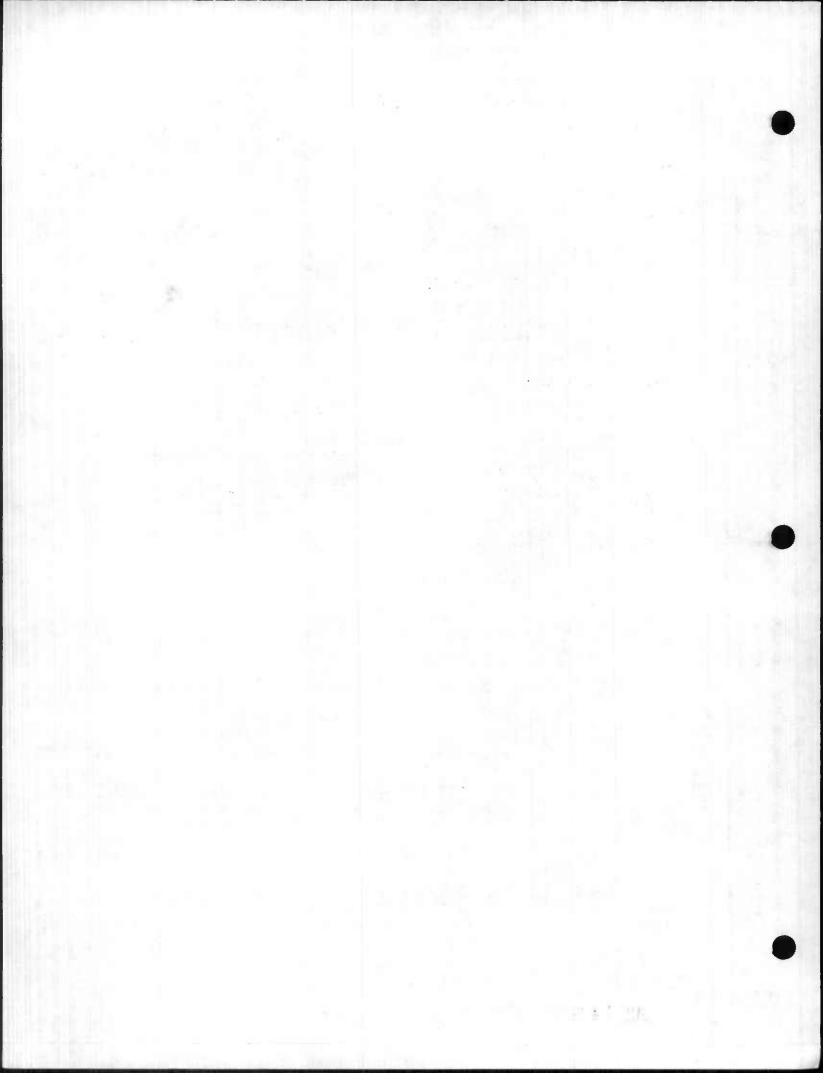
#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 12, 1999 Year **Physician** Clarence E. Wootten, Jr. 3:15PM /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not Institution, give street end number) 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Yeer | If Under 24 Hrs. 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 217-14-6220 Hours 10XM 2□F Sept. 1, 1921 Annapolis, MD. Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ma 23a or 28a-f abov must be notified at Maryland Anne Arundel Annapolis 1 No Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? hama 23a or 108 Hickory Lane 21403 USA Funeral 12. Was Decedent Ever in U,S.
Armed Forces?
1 [2] Yes 2 □ No WWII
If Yes, Give
Year or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 Yes ZONo 8 Baltimore, Maryland 21215-0020 Specify: Specify: White þ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Antennae Rigger 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiena. Wher than College (1-4or 5+) Federal Government 11th 7 is marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Clarence E. Wootten.Sr. Lillian C. Ouade 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) nt of Health a If Item 27 is or other tra Donna Blanchard/Daughter 2078 Ingleside Ct. Crofton, MD. 2114 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 □ Cremation 3 □ Removel from State Hillcrest Memorial Gardens7/15/99 Annapolis, MD. 4 Donation 5 Other (Specify) 21. Signature George P. Kalas Funeral Home, P.A. eral Senice License also 2973 Solomons Island Rd. Edgewater, MD. 21037 Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, or heart failure. List only one call to one each line. Approximete Interval Between Onset and Death Physician /Medical Immediate Cause (Finel Chronic Obstructive Lung Disease 10 yrs. disease or condition resulting in death) Examiner Due to (or as a consequence ot): Examiner Acute Renal Failure 2 months physician and the burial-transit or Attanding Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequenca of): Box 68760. Physician/Medical Due to (or es e consequence of) 88 ate has been signed by the attending page 2 should be detached for use 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1XYss 2□ No 3 Probably 4 Unknown Division of Vital Records. Be Completed by 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was en autopsy performed? 1 Yes 2XXNo 1 ☐ Yes 2 ☐ No certificate director, 25. Was case reterred to medical 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA this funeral 28e. Date of Injury (Month, Dey Year) 27. Magner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1 Naturel e Hospital or Attanding 124 hours after death. • Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29e. Certifier 1 🔁 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete and place, and due to the cause(s) and menner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stalled. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certitier D5181 July 13, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Matthew Malta, M.D. 1833 A Forest Dr. Annapolis, MD. 21401 31. Date filed (Month, Dey, Year) 32. Registrer's Signature State 1 4 1999 Registrar

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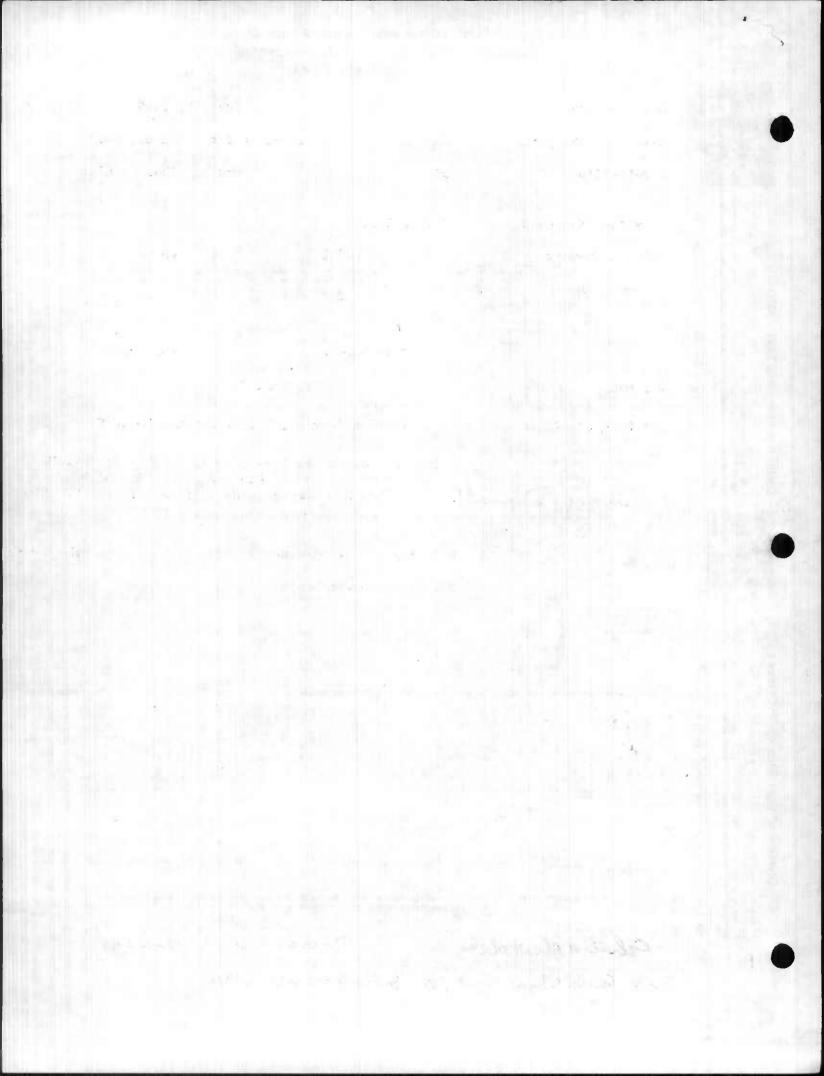
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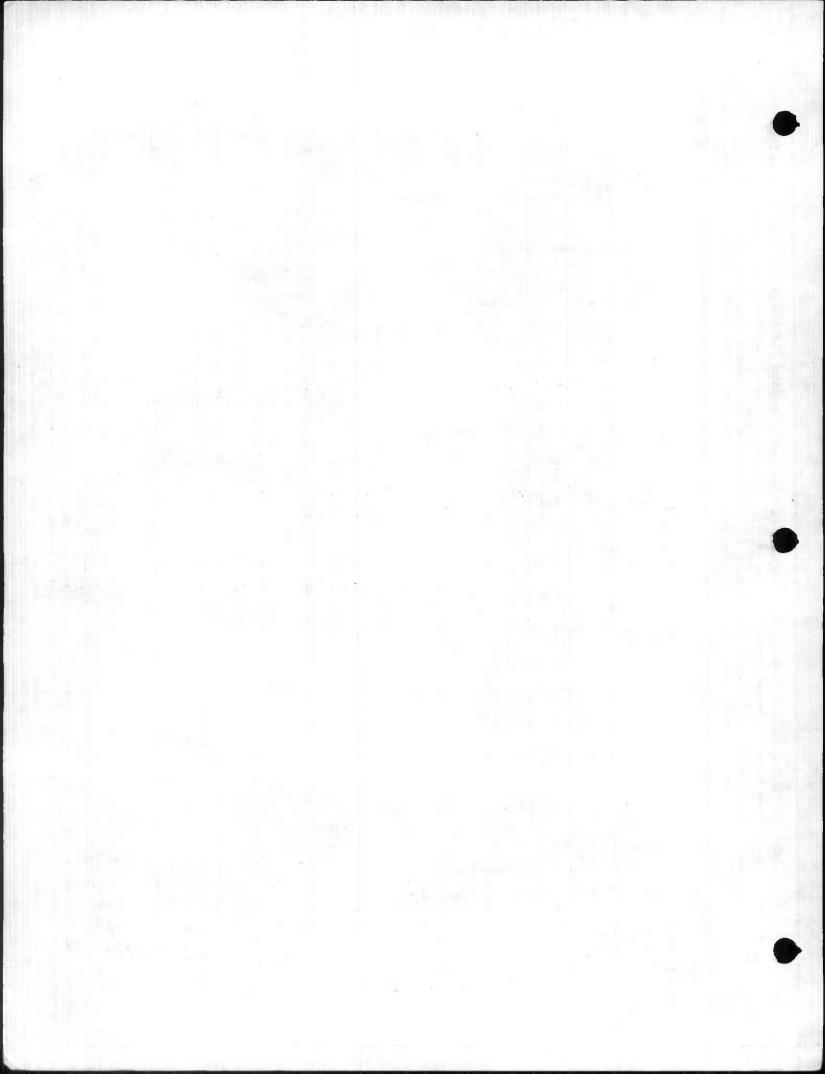
State of Maryland / Department of Health and Mental Hygiene Q O 91.1.9 c

Physician /Medical Examiner	Decedent's Neme (First, Middle, Last)     Ethel L. Watk     Facility Name (Iff not Institution, give s				2. Date of Death Month	Day		Time of Deeth	
/Medical Examiner	4a Facility Name (If not institution, give :	ins							
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Funeral	Franklin Squa	are Hospital		4b. City, Town, or Lo Rosedale		4c. County Balti			
Director	5. Social Security Number 6. Sex 242-48-6339	7. Age (In yrs. le	Yrs. If Under 1 Months C	lays Hours Min.	8. Date of Birth (Month, Day, You Aug 19,	ear) 1933	9. Birthplace (State or Foreign Country) Hoffman, NC		
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23a or 28a-f a	10e. Street and Number 6052 St. Regi	st RD.	10f. Zip Co 21 2 (	Vhat Country?					
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L		npleted cause of death (Item	One) Chara Brine)		,	-		-	

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State Registrar

31. Determed Month, Dai Pear, Oung



State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMENDED ITEM #3 & #30 PER MB G774 8/24/99 AH 2. Date of Death 1. Decedent's Nama (First, Middla, Last) 3. Time of Death Day Month Physician Year JULY 16 1999 11:45 PMAM BETTY ASHBY WHITESEL /Medical 4b. City. Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner MONTGOMERY HOLY CROSS HOSPITAL SILVER SPRING If Undar 1 Yaar If Under 24 Hrs. Birthplaca (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 27X 73 Yrs. Director 579-26-2089 AUG. 14 1925 MARYLAND Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. Stata 10b. County naturel, or items 23s or 28s-f show officel Examiner must be notified at MARYLAND MONTGOMERY SILVER SPRING MYes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20906 UNITED STATES 13115 HATHAWAY DRIVE death \ Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "naturel", or iten any injury or other traumetic event, its Medical page. 1 ☐ Yas 2 No If Yes, Give Year or Datas: 1 Never Married 2 X Married Specify: WHITE /Baltimore, Maryland 21215-0020 1 Yas No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 ADMINISTRATIVE ASSISTANT EDUCATION 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be JOHN HERBERT ASHBY ANNIE RAY MENEFEE 19a, Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Straat and Number or Rural Route Number, City or Town, Stata, Zip Code) ROY T. WHITESEL HUSBAND 13115 HATHAWAY DR. SILVER SPRING, MD. 20906 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20e. Mathod of Disposition XXBuriat 2 Cremation 3 Removal from State 7-21-99 WARRENTON, VIRGINIA 4 ☐ Donation 5 ☐ Other (Specify) WARRENTON CEMETERY Funeral Service Lic 22. Nama and Addrass of Facility HINES-RINALDI F.H. INC. Frans 11800 NEW HAMPSHIRE AVE. SILVER SPRING, MD. 20904 orus ( L 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onsat and Death **Physician** Immediata Cause (Final disaase or condition resulting in death) /Medical ACUTE MYOCARDIAL INFARCTION 5 DAYS **Examiner** Dua to (or as a consequence of). Examiner YEARS CORONARY ARTERY DISEASE physician and the burial-transit The law requires that the death certificate be asscuted Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or Injury that initiated evants resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Dua to (or as a consequence of): 88 attanding p ed by the a 23b. Did tobacco use contributa to the cause of death? Part It, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 0 signed by t d be datach 1 Yes AN No 3 Probably 4 Unknown Records, P. þ 24b. Were autopsy findings available prior to should should 24a. Was an autopsy performed? Completed completion of causa of death? has 1 ☐ Yes 2 ☒ No 1 Yes 2 No certificate Division of Vital Physician: 25. Was case referred to medical examinar? Be 26. Placa of Death (Chack only one) Hospital: 2 ER/Outpatient 3 DOA 1 Yes 2XXNo Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) P Aftar this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. tnjury at Work? 28d. Describe how injury occurred Certification: or Attending 1 X Natural 5 Pending investigation in 24 hours are:
the Funerel Director: Aft
aletely filled in by the fu 1 Tas 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Cartifier \*\* Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and mannar as stated

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the tima, data and place, and due to the On the basis of examination and/or investigation, in my opinion, death occurred at tha tima, data and place, and dua to the causa(s) and manner stated. (Check or one) To the To the F 29c. Licansa number 29d. Date signed (Month, Day, Year) 29b. Signatur and titla of certifie 0 D005568 JULY 16, 1999 30. Name and address of person who completed cause of death (tem 23a) (Type, Print) SAMUEL' 10313 GEORGIA AVE. #307 SILVER SPRING, MD 20902 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1999

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Registrar

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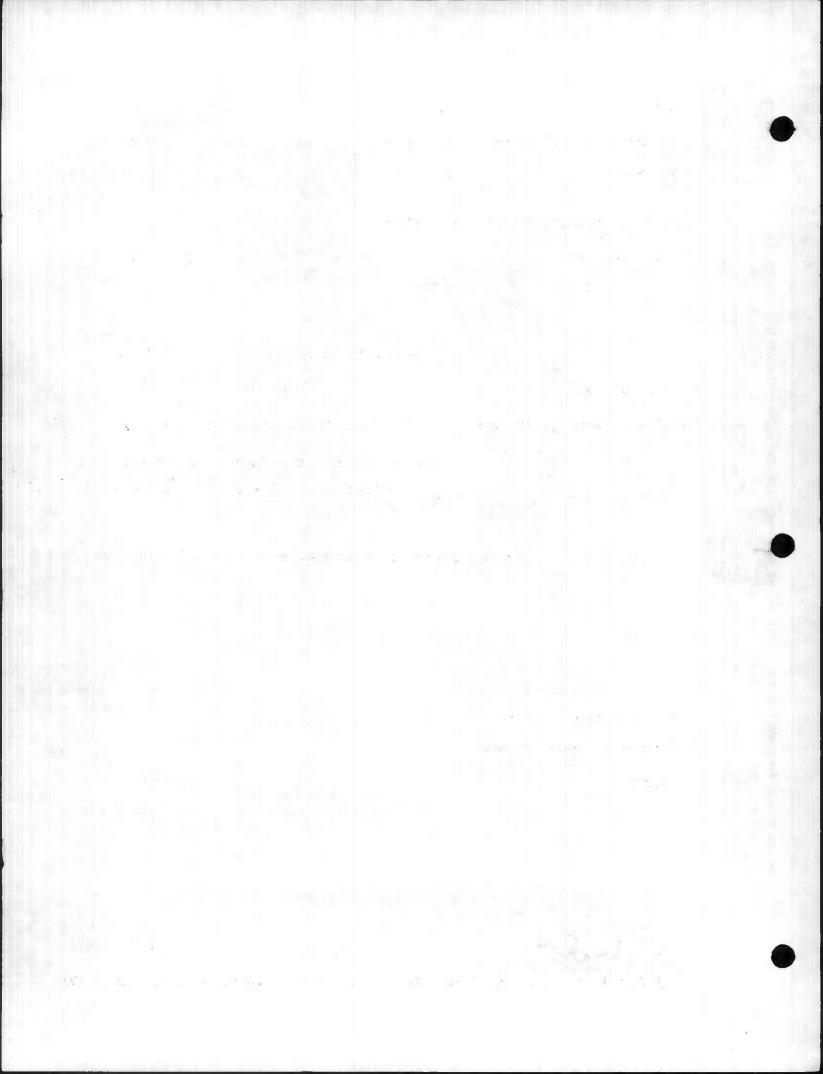
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			Decedent's Name (First, Middle, L	ast)		Ce	ertificate of	Death	2. Dete of D			3. Tima of Death	
	Physicia /Medic		John	W:	illcox,	Jr.			July	19, 1999	Year )	8:00 AM	
ř	Examin		4a Facility Neme (If not institution, g					4b. City, Town, or			y of Death		
			Fox Chase Rehabi  5. Social Security Number 6.	Litation Sex	7. Age (In yrs.		7	Silver	s. 8. Date of B	irth	gomer 9 Birthol	e e e e e e e e e e e e e e e e e e e	
L	Funeral Director		232-30-9931 Usual Residence of Decedent	1⊠M 2□ F	77	Yrs.	Months Days	Hours Min		, 1921		eca (Stete or Foreign try) n Carolina	
	ehow		10a. Stete 10b. County		10c. Ci	ty, Town or I	ocation				10	Od. Inside City Limits	
	Man	tor	North Carolina Cumberl	and	Нор	e Mil	ls					1 ☐ Yes 2 📉 No	
	章 50	Director	10e. Street end Number				10f. Zip Code			10g. Citizen of	Whet Coun	try?	
	ath w		1516 Abella Road				28348			United			
	item item	Funerai	11. Maritel Status  1 ☐ Never Merried 2 ☒ Married		orces?		. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (: en, Mexican, Pue	Specify Yes or N rto Rican, etc.)		ce - America ick, White, e		
020	within 72 hours efter death with the Marylend ene. then "naturel", or items 23e or 28e-1 ehow for Maylcal Examinel must be notified.	þ	3 Widowed 4 Divorced	If Yes, G Year or I	orces? 2 No 194 ive Dates: 1	971	1 ☐ Yes 2 No	Specify:		Speci	y: Whi	te	
2-0	n 72 hours "naturel",	eted	15. Decedent's ( (Specify only highest g			(Giv	edent's Usuel Occup to kind of work done	during most of wo	orking	16b. Kind of E			
0200-61212	jene. r then	Completed	Elementary/Secondary (0-12)	College	1-4or 5+)	life	DO NOT use retire	od)		United		es	
	Ten 100 to 100	ပိ	17. Father's Neme (First, Middle, Las	3		Com	missioned	1	ame (First, Middl	Air Fo			
Maryland	d 2 should be filed the and Mentel Hyg 7 is marked other traumatic event,	o Be	John Willcox					Mamie	Gee				
ary	end Nema		19e. Informent's Neme/Reletionship	(Type, Print)		19b. Ma	iling Address (Street	and Number or F	r Rural Route Number, City or Town, Stete, Zip Code)				
	of Health item 27 I		Archie E. Barring	er/Past	or	227	1 Jenna S	hane Dri	rive, Fayetteville, NC 28306				
0	# ite		20e. Method of Disposition 1 X Buriel 2 ☐ Cremation 3	☐Removal from	State 20b.	cemetery, cr	position (Neme of emetory or other ple	ce) July 2	2, 1999 20c. Location - City or Town, Stete				
saitimore,	permit. Pages 1 Depertment of H Important: if its eny Injury or ot pnce.		4 ☐ Donation 5 ☐ Other (Spec		Lat	fayett	e Memoria	l Park W	lest	Fayette		, NC neral Home,	
0			21. Signatur Carrieral Salvice Li	200		B	ethesda-C	hevy Cha	se, Inc.	7557	Wiscon	nsin Ave.	
)			23a. Pert1. Enter the disease, or cor	nplications that	used the deel	1803 E	ethesda, I	Maryland ng, such as cardie	20814- ec or respiretory	-3501 errest,		Approximate	
	Physician		shock, or heart feilure. List ont	y one cause on	eech line.							Onset and Death	
Ļ	/Medical		Immediate Cause (Final disease or condition	. Poor1	v Diffe	renti	ated Metas	tatic Car	ncer of	Unknown (	Origin	Months	
	Examiner		resulting in death)	6.			equence of):						
1	betr Insit	Examiner		b	D. s. t.s. fr		- A						
2	executed in and rial-transit	Еха	Sequentielly list conditions, If any, leading to immediate cause. Enter Underlying										
2/00	icate be executed physician and s the burial-transit	Ical	Cause (Disease or Injury c.										
190	leath certificate t ettending physical for use es the t	by Physician/Medic	resulting in death) Last										
DOX	death ce e ettend e for us	lan		0									
ċ	ires that the death signed by the ette d be detached for	iysic	Part II. Other significant conditions	contributing to o	leath but not res	ulting In the	underlying cause gi	ven in Pert I.				the cause of death?	
, v	that the pad by deta	y P	Coronary Artery	Disease	2				. 1	]Yss 2□No	3K Prot	ably 4 Unknown	
Cords	v requires been sign should be		Company Hanni	. Pailus	• •				24a. We	s an eutopsy formed?	24b. We	ere autopsy findings	
222	aw 2 s b	Completed	Congestive Heart	. rallui	e				po		cor	mpletion of cause death?	
r	The ate h	E CO	Emphysema						10	Yes Z No	1 [	Yes 2 No	
N Tal	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical exeminer?	Managhal			100		eeth (Check only				
0		-T	1 Yes 2 No 27. Manner of Deeth	Hospital: 1  28e. Dete		ER/Outpati	ent 3LI DUA		Home 5 Res	how injury occu		1)	
	th. : After e funer	ation	1 Netural 5 Pending 2 Accident investigation	(Mor	oth, Day Year)	Injury	Wo	rk? ]Yes 2 □ No	200. 0000100	s now injury occu			
UNISION	or Attanding F safter death. I Director: After d in by the funer	Certification:	3 Sulcide 6 Could not determine	289. PIBC						28f. Location (Street end Number or Rural Route Number, City or Town, State)			
2	putal o		20a Cartifier 1 M Cartifidae D	busision. To the	bost of my kee	udodeo do	ath conversed at the ti	me date and place	and due to the	a acusada) and a	onnor on ni	atad	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai		minar: On the b			ath occurred at the ti investigation, in my o						
	To the To the Comp	M	29b. Signature and title of cartifier				29c. Licen	se number		29d. Date sign	ed (Month, i	Day, Year)	
	10+1		hugh	7			D42	403		July	19, 19	99	
•	1		30. Name and eddress of person who	completed cau	se of deeth (Iter	n 23e) (Type	e, Print)						
		-	Raj P. Mathur, M		6 Truin	o Stra	et. Nul	218 Was	shington	D C	20010	-2975	

State Registrar

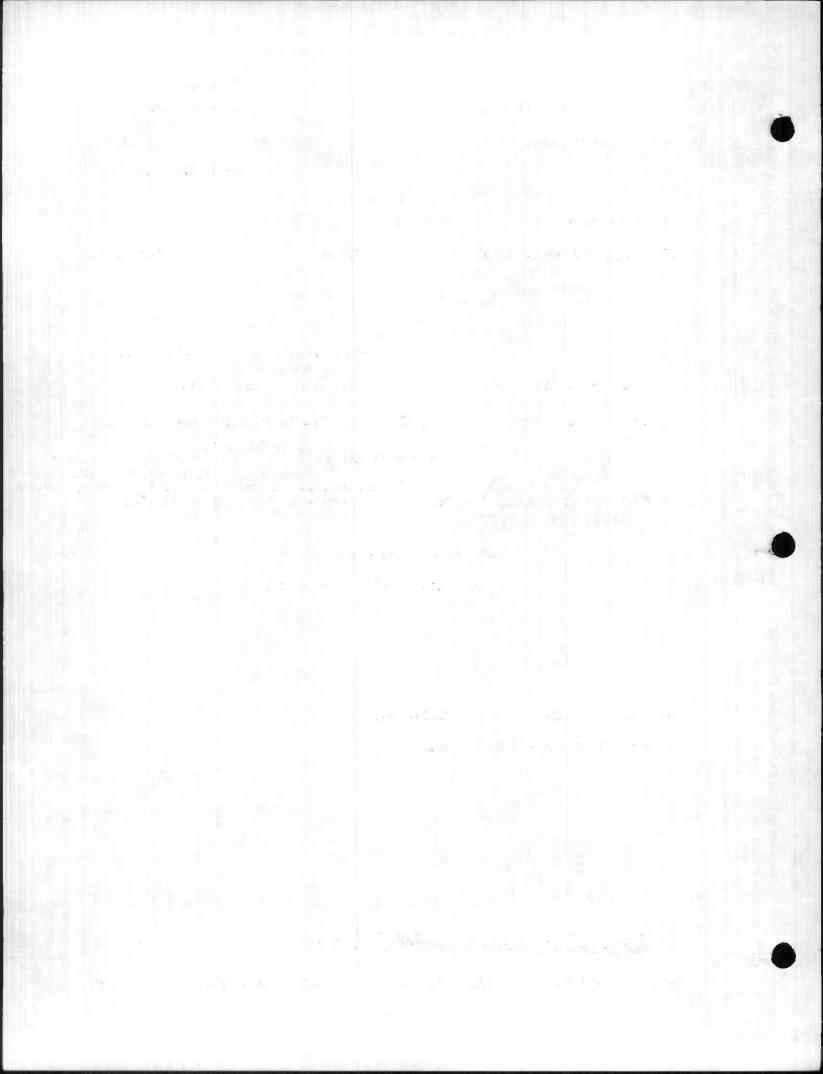
31. Date filed (Month, Day, Year)

32. Registrar's Signature



			Pleas	State of M		I / Depa		Health and N	Mental Hyg		ole.	1:39		
			1. Decedent's Name (First, Middle,	Last)					2. Date of Dea			3. Tima of Death		
	Physici /Medic		Russell H	I. Williams	S				July 19	9, 1999	Year	2:05 AM		
	Examir		4a Facility Name (If not institution,	give street and number	)			4b. City, Town, or L		-	of Death			
			4515 Sangamore H	Road, #203				Bethesda		Montg				
E	Funeral Director		577-05-1879	8. Sax 7. A 1⊠ M 2□ F	ge (In yrs. la 85	st birthday) Yrs.	Months Days		8. Date of Birtl (Month, Day March 2	0, 1914	9. Birthp Coun Virg	laca (Stata or Foreign try) inia		
	pu .		Usual Residence of Decedent  10a. State 10b. County		10c City	Town or Lo	cation				1	0d. Inside City Limits		
	eho	5										1 ☐ Yes 2 K No		
	28a-	ect	Maryland Montgon	nery	Бег	hesda	10f, Zip Code			10g. Citizen of V	Vhat Cour	trv?		
	With with	0	4515 Sangamore H	Road. #203			20816			United				
	Seeth 22	era	11. Marital Status	12. Was Decedent	Evar in U,S	. 13.1			pecify Yas or No-		e - Amaric	an Indian,		
0200-91212	hours after deeth with the Maryland ural', or flems 23s or 28s-f ehow at Examinet must be notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	Armed Forces				13. Was Decedent of Hispenic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:			k, White, "Whi			
Ş	"natural",	8	15. Decedent	s Education	16a. Decedent's Usual Occ			pation	leto e	16b. Kind of Bu	siness/inc	dustry		
7	nd 2 should be filed within 72 ho alth and Mental Hygiene. 27 is merked other than "natur or traumatic event, the Medical	Completed	(Specify only highest Elementary/Secondary (0-12)	T T	completed) (Give kind of work do life. DO NOT use rel			ed)	ung					
7	od wil	Con	12			Proprietor				Floral				
Maryland	al de H	Be	17. Fathar's Name (First, Middle, L						e (First, Middle,	Meiden Sumam	0)			
<u>×</u>	Meni	2	Charles Madisor	n Williams							Lacy			
ā	and and is m		19a. Informant's Name/Relationship (Type, Print)  19b. Malling Address (Street and Number or Run											
2	of Health of Health item 27 i		Robert F. Coope		Maryland 20850									
Baitimore,	permit. Pages Department of I Important: If its any injury or of		20a. Mathod of Disposition  1 XBuriel 2 Cramation  4 Donation 5 Other (Sp  21. Signature of Funeral Survival L	ecify)	Ced	lar Hi Be	thesda-C	ery ess of Facility Ro Chevy Chas	bert A. e, Inc.	Suitland Pumphre 7557 V	d, Ma ey Fu Visco			
	Physician		23a. Partt Error the disease, or a special printer trailing. List of	complications that cause only one cause on each	M006 d the death. line.			esda, Mar ing, such as cardiac			)1	Approximate Interval Between Onset and Death		
*	/Medical Examiner		tmmediate Ceuse (Final disease or condition resulting in death)	e. Ische		ardio	myopathy					3 Years		
-	p .≅	ner		Нурез	rtensi	ve Ca	rdiovasc	ular Dise	ase			15 Years		
<b>60</b> ,	be executed ician end buriat-transit	Examiner	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying											
BOX 68/6	es that the death certificate by igned by the attending physic be detached for use as the b	Physician/Medical	Cause (Disease or Injury that initiated events rasulting In death) Last	that initiated events										
	death e atte	icia	Part It. Other etgnificant conditions contributing to death but not resulting in the underlying cause given in Part I.							obecco use co	ntribute to	the cause of death?		
, r	that the	by Phys	Diabetes Melli							Yee 2 No		bably 4 Unknown		
ecords	requir been s should	Completed b	Chronic Obstru	ctive Lung	Disea	se			24e. Was perfo	an autopsy med?	av	ere autopsy findings eilable prior to mpletion of cause death?		
r	8 - 2	E							101	res 2 No	1[	Yes 2 No		
VItal	certificate	0	25. Wes case referred to medical					26. Plece of Dee	th (Check only o	ne)				
	E 10 TO	To B	exeminer? 1 ☐ Yes 2 💢 No	Hospital: 1 ☐ Inpat	ient 2 🗆 E	R/Outpatier	nt 3 DOA	ther: 4 Nursing H	ome 5 🕅 Rasio	dence 6 □Oth	er (Specif	y)		
lon or	는 등 등		27. Manner of Death  1    Naturel  2   Accident  Accident  S   Pending Invastig		ay Year)	28b. Time o Injury	We	ury et ork? Yes 2 \( \text{No}	28d. Describe	now Injury occur	red			
DIVISION	frar frac in by	Certification:	3 Suicida 6 Could n 4 Homicide determine	ned   28e. Place of Ir	njury - At hon etc. <i>(Specify)</i>	na, farm, sti	eat, factory, office		28f. Location (S City or Tox	ation (Street and Number or Rural Route Number, or Town, State)				
	To the Hospital or At within 24 hours eftar of To the Funeral Direct completely filled in by	edicai		Physician: To the best examtner: On the basis and manner s	of examinetic									
	4	×	29b. Signature and titla of certifier	ue seline	udi	THE	29c. Licen D263	se number		29d. Date signe July 19				
	20+1		30. Name and address of person v	who completed cause of	death (Item :	23a) (Type,	Print)							
			Marta Schneider	, M.D. 540	1 MacA	Arthur	Blvd.,	N.W. Was	hington	, D.C.	2001	.6		
	Sta Registr	_	31. Dete filed (Month, Day, Yeer)	32. Regis	trar's Signatu		free							
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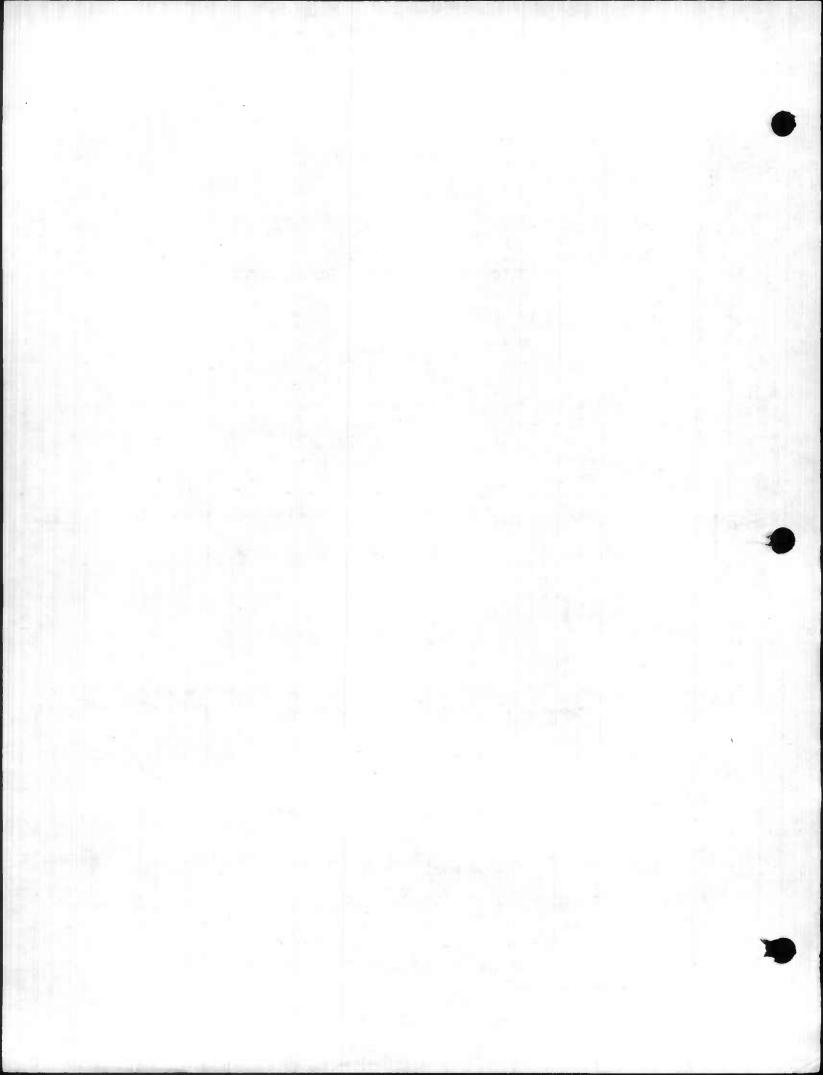


### Please Type or Print in Biack indelibie Ink. Assure Ail Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

				Certifica	te of	Death		Reg. No.	1	HHU	
	1. Decedent's Neme (First, Middle, La	st)					2. Date of De Month				
Physician /Medical	WINIFRED WOODBIN	E					JULY			8:55 P.M	
Examiner	4e Facility Neme (If not institution, gir	re street end number)				4b. City, Town, o	r Location of Deat	h 4c. County	of Death		
	Fairland Adventi	st Nursing	Home			Silver		Mont	gome	ry	
Funeral Director	212-96-2595	Sex 7. Age 1 □ M 2 X F	(In yrs. last bi	rthday) If Unde Months	Days		n. (Month, De	th by. Year) 5, 1904	Coun	ntry)	
natural, or items 23a or 28a-f ahow dical Example mant be notified at eted by Funeral Director	Usuel Residence of Decedent  10a. Stete 10b. County		10c. City, Tow	n or Location					1		
or 28a-f at the northed	Maryland Montgo	mery	Silve	r Spring							
thems 23a or 28a-f show ther must be notified at Funeral Director	10e. Street and Number 8605 Carroll Ave				p Code 1903			USA	What Cour	itry?	
by l	11. Maritel Stetus  1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes:		13. Wes Dece If Yes, spo	ecify Cub	an, Mexican, Pue	erto Rican, etc.) Black, White,			elc.	
natural distriction of the second	15. Decedent's E (Specify only highest gr		16a	Decedent's Usu	el Occu	pation	nekina	16b. Kind of B	usiness/Inc	dustry	
omo	Elementery/Secondery (0-12)	College (1-4or 5+)		Seamstre		during most of w d)	UKNIY	Tailo	ring		
=	17. Father's Neme (First, Middle, Last	)				18. Mother's No	ame (First, Middle				
raumatic eva To Be	John Woodbine					Olivia	Hall		ounty of Death Ontgomery  9. Birthplece (State or Foreign Country) Jamaica  10d. Inside City Limits 1		
The Party	19a. Informent's Neme/Reletionship	Type, Print)	198	19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Str						Code)	
	Hope Cameron/Dau	ghter		8605 Carroll Ave, Silver Spring, MD 20903							
otho	20a. Method of Disposition		20b. Place o	Disposition (Na	me of		Date		_		
eny injury or poce.	1 Buriel 2 Cremetion 3 4 Donation 5 Other (Special	לא)		e of Heaven Cemetery   Jul 26 Silver Spring, MD  22. Name and Address of Facility Hines-Rinaldi Funeral Home							
eny ir	21. Signeture of Funerel Service Lice	Somell									
cian	23a. Pert1. Enter the disease of corr shock, or heart failure. List only	plications that caused the one cause on each line					•		1	Interval Between	
ledical aminer	Immediate Cause (Finel disease or condition resulting in deeth)  Due to (or as a consequence of):										
hel-transit Examiner		b									
he bu	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as e consequence of):										
3		d									
ed for use	Pert II. Other algnificant conditions of	ontributing to death but	not resulting i	n the underlying	cause gi	ven in Pert I.	23b. Did tobecco use contribute to the cause of deal				
be detached for use by Physiclan/I		shere Uc					10	Yes 2046	3 Pro	bably 4 Unknow	
should								an autopsy ormed?	87	railable prior to impletion of cause	
Page 2							10	Yes 2 ANO	10	☐Yes 2☐No	
rector, pa	25. Was case referred to medical					26. Place of D	eeth (Check only	one)			
0 0	examiner?	Hospital: 1 ☐ Inpatient	2□ER/O	stpatient 3 D	OA Ot	her: 4 4 Nursing	Home 5 ☐ Resi	dence 6 □Ott	her (Specif	(y)	
	27. Menner of Deeth  1 (Chatural 5 Pending investigation	28a. Dete of Injury (Month, Day)	Year) 28b.	Time of Injury M	28c. Inju Wo			how injury occur			
	3 Suicide 6 Could not be determined	28e. Plece of Injury building, etc.	y - At home, fa (Specify)	trm, street, facto	ry, office		28f. Location ( City or To		ber or Run	al Route Number,	
completely filled in by Medical Certifi		ysician: To the best of niner: On the basis of e end menner state	xamination en								
completely filled	29b. Signeture end title of certifier  Machine /	Kendent	3mD			se number 6					
	30. Name and address of person who	completed cause of dea	th (Item 23a)	(Type, Print)			·				
	Andrew Kundra	8317 Cher	ry Ln,	Laurel,	MD	20707					
State	31. Dete filed (Month, Dey, Year)	32. Registrar	s Signature	,	,					1	
- mintros	1111 9 9 40	00 K.									

DHMH 16 Ray 6/95



Baltimore, Maryland 21215-0020

F	Please			d / Depa	artment of	Health a	and N	ii Copies A Mental Hygi	-	ible.	لبلبلبا
				Cei	rtificate of	f Death		Re	g. No.		
1. Decedent's Name (First,	, Middle, Las	st)						2. Date of Deeth Month	Dey	Year	3. Time of Deeth
Ir	vin	Elmer	Wagr	ner				July 2	3, 199		11:25 AM
4a Facility Name (If not Ins						4b. City, To	own, or L	ocation of Death	4c. Count	y of Deeth	
Memorial H	lospi	tal at	East	on		Eas	stor	1	Tall	bot	
5. Social Security Number	6. Se	iex	7. Age (In yrs.		If Under 1 Yaa Months Day		r 24 Hrs.	8. Dete of Birth (Month, Day,	Vasrl	9. Birthp	olece (Stete or Foreign
202-20-9583 Usual Residence of Deced		IXM 2□ F	89	9 Yrs.	Months Day	rs Hours	IVIII i.	October 7			yland
	County		10c. Cit	y, Town or Lo	ocation					1	10d. inside City Limits
Maryland C	aroli	ne		Denton	1						1 ☐ Yes 2 ☑No
10e. Street and Number					10f. Zip Code			10	g. Citizen of	What Cour	ntry?
9984 Reed Ro	her				216	29			United	Stat	-00
11. Marital Status	au	12. Was Dec	edent Ever in U	,S. 13.	Was Decedent of	f Hispanic Or	rigin? (Sp	pecify Yes or No-	14. Ra	ce - Americ	can Indian,
1 Never Married 2	Married	Armed Fo	2 No		If Yes, specify Cu			Rican, etc.)	- 100	ick, White,	etc.
3 ☐ Widowed 4 ☐ Div		If Yes, Giv Yeer or D	ve		1 □ Yes 200 N	<sub>ly:</sub> Icasia	an				
(Specify only		de completed)		(Give	edent's Usual Occ e kind of work don DO NOT use reti	ne dunna mos	st of worl		16b. Kind of E		7.0
Elementery/Secondary (I	0-12)	College (1	1-4or 5+)		armer	0-,			Fo	rmino	
17. Father's Name (First, N	viiddle, Last)			10	IIIIEI	18. Moth	er's Nam	ne (First, Middle, M		-	,
Hen		harles	Wagner					King			
19a. Informant's Neme/Re		Type, Print)		19b. Meilir	ng Address (Stre	et end Numb	er or Ru	ral Route Number,	City or Towr	, Stete, Zij	Code)
Elisabeth Wa	gner		Wife			oad, D	ento	n, Maryl		21629	
20a. Method of Disposition 1	nation 3 🗇		State Med	chanic	osition (Neme of emetow or other p S Grove Inren Cen				20c. Location  Duarry		own, State nia , Pennsylva
21. Signature of Funeral Signa	oper	110	Toore	M	2. Name and Add Moore Full 12 South	neral Secon	Home	P.A.	nton,		land 21629
shock, or heart feilure	e. List only	one cause on e	each line.								interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)		a atte	ro scler	otic	Heart a	desse	are				gears
	DUR TO IE	or as e consec	duence of):						years		
Sequentially list conditions if any, leading to immediat cause. Enter Underlying Ceuse (Diseese or injury	s,		D	or as a consec			J				
thet initiated events resulting in death) Last		C	Due to (c	or as a consec	quence of):						
	L	d									
Daniel Other significant o	-ndiffone o	and the state of	and had not ros	white in the s	agues polyholt a	chies in Dari	2	23b Did to	hacco use c	ontribute t	to the cause of death?
Part II. Other significant of	- 1-	C GUIC		nging in the a	inderlying cause	given in ren			a 2 No	3 □ Pro	- 0

**Physician** /Medical Examiner

been signed by the attending physician and should be detached for use as the burial-transit

To the Mospital or Attending Physician: The law requires that the death certificate be executed

within 24 hours after death.

To the Funeral Director: After this certificata has completely filled in by the funeral director, page 2.

Division of Vital Records, P.O. Box 68760,

Physician/Medical Examiner

Be Completed by

Certification: To

Medical

Director

Be Completed by Funeral

**Physician** /Medical

**Examiner** 

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Internet of Health and Mental Hygiene. Internet if item 23 e or 28e-f show any introduction of the result of the marked other than 'naturel', or items 23e or 28e-f show any introduction of the rotified at any introduction.

Part II. Other 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 21 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residenca 8 Other (Specify) 1 ☐ Yes 217 No 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Natural 5 Pending 1 ☐ Yes 2 □ No 2 Accident Investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

29a. Certifier (Check only one) 29b. Signature and title of cartifier

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end pleca, end due to the cause(s) and manner as steled.

2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated. 29c. License number

D46020

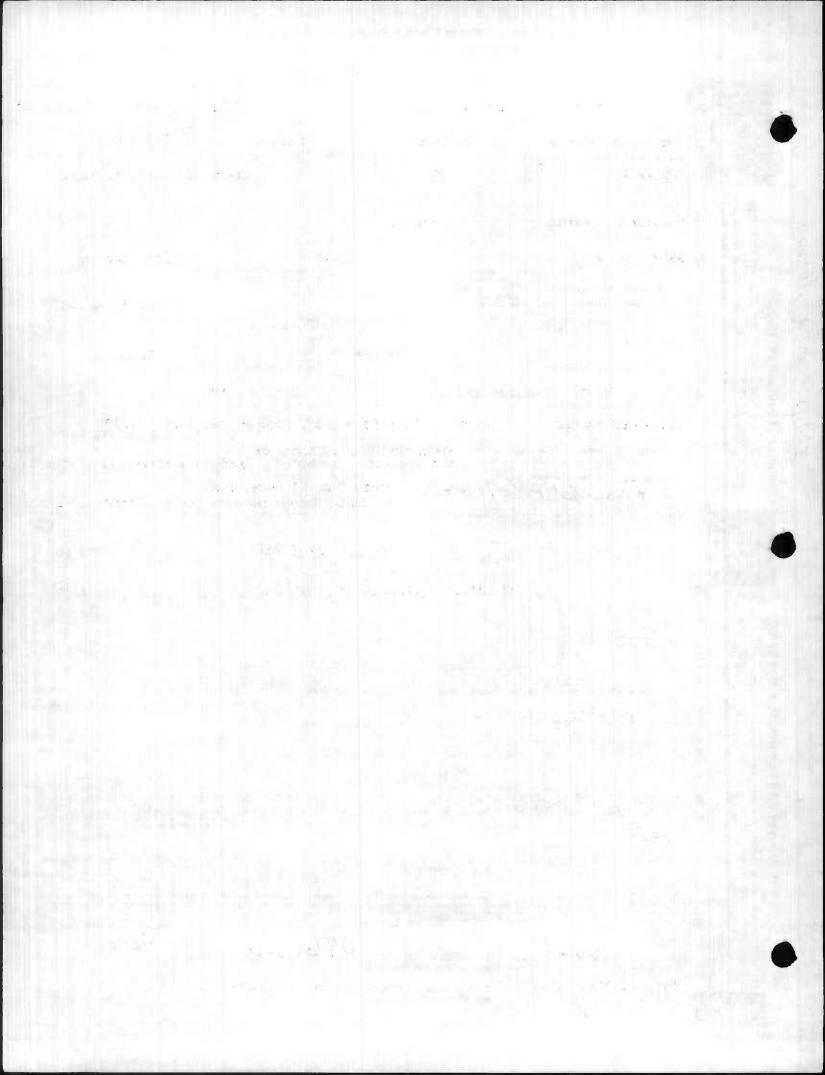
29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Syed I. Ali, M.D. 506 Idlewild Avenue, Easton, Maryland 21601 31. Date filed (Month, Dey, Year)

JUL 2

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death **Physician** 04-2 AM 4c. County of Dea Richard 08 20 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Baltimore of Marvana H Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
SEP . 14, 1933 If Under 1 Year 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 10M 20F 236-48-6271 Virginia Director Usual Residence of Decedent the Maryland 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ahom "natural", or items 23s or 28s-f show 1 Yes 2 No Director MD N/A Baltimore 10e Street and Number 10f Zin Code 10g Citizen of What Country? 21223 **JSA** 235 S. Gilmore Street Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 13 Yes 2 1 No If Yes, Give Year or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. of 2 should be filed within 72 hours after (ith and Mental Hygiene. ?? Is marked other than "natural; or fiel traumatic avent, to Medical Exercises. 1 ☐ Never Merried 2 ☐ Merried Baitimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 8 Pipe Fitter Industrial 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) permit. Pagas 1 end 2 should be file Department of Haalth and Mental Hy Important: If item 27 is marked othe any Injury or other traumatic avent pace. Be Leman Ashbrook Pansy Woodall 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 235 S. Gilmore St., Balto., Md. Betty E. Ashbrook - wife 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Date 8/03/99 1 ☐ Buriel 2 X Cremetion 3 ☐ Removel from Stete 4 □ Donetion 5 □ Other (Specify) Baltimore Washington Crm. Laurel, Md. 22. Name and Address of Facility
Gary L. Kaufman Funeral Home @Meadowridge MP, Inc. 21. Signature of Funerel Service Um 7250 Washington Blvd., Elkridge, 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting In death) /Medical Examiner Examiner Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last The law requires that the death certificate be execu physician sthe burial Box 68760. Physician/Medical Due to (or as a consequence of): P.O. 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vitai Records, Be Completed by 24b. Were sutopsy findings available prior to completion of ceuse of death? 24a. Wes an autopsy performed? end du or Attending Physician: 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To this 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? Aftar 5 Pending investigation n 24 hours after death.

Ne Funeral Director: After pleter filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. 29e. Certifier To the Hosp within 24 hou To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number Torres, MD 12500

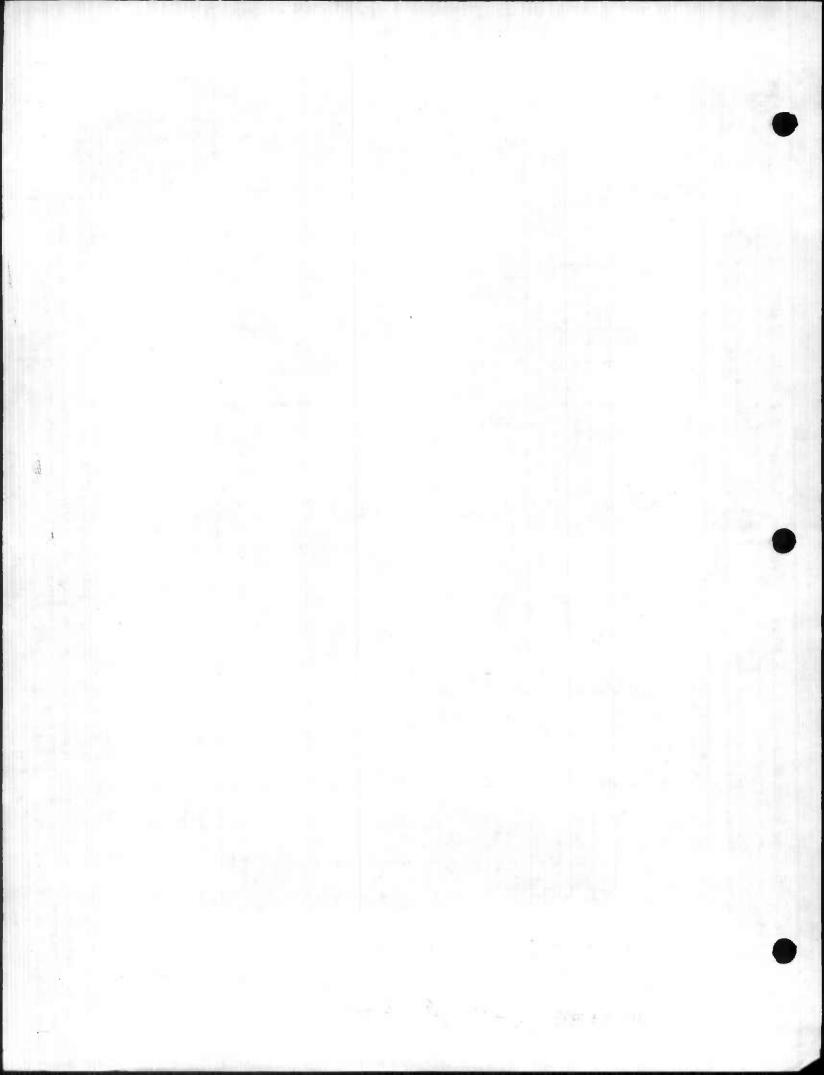
State Registrar

AUG 04 1999 **DHMH 16 Rev 6/95** 

31. Date filed (Month, Dey, Year)

University of Maryland 32. Registrer's Signeture

30. Name and eddress of parson who completed cause of deeth (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene QQ AMEND ITEMS: #27 PER G764 8-4-99 WR. Certificate of Death 2. Date of Death 3. Tima of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Ruth Armon 1999 8:10 am Ju<sub>1</sub>y 18 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not Institution, give street and number) Examiner Atlantic General Hospital Ocean City Worcester If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) If Under 1 Year Birthplaca (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□ M 2X F Months Days Yrs. 85 May 28, 1914 034-03-4164 **Director** Mass. Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Worcester Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? an "natural", or items 23s or Medicsi Examiner must be r 9003 Mediterranean Drive 21842 U.S.A. Funeral 14. Raca - American Indien, Black, White, etc. 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 ☐ Yes 2 📉 No If Yes, Give Yeer or Dates: 1 ☐ Never Merried 25 Merried 1 ☐ Yes 2 ☑ No Specify: Specify: white à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Janitorial Service Elementary/Secondary (0-12) College (1-4or 5+) Secretary and Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be Mental Louis Saltman Jenny Caplan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 George Armon/spouse of Health Itam 27 9003 Mediterranean Drive, OCean City, MD 21842 20b. Place of Disposition (Neme of cemetery, crematory or other placa) 20c. Location - City or Town, Stele 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Wase Director Ropald S State Anatomy Board, 655 W. Baltimore Street Baltimore, MD 21201 Pa 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** renal failure Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Examiner 51 and I-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest Due to (or es a consequence ot): physician ar s the burial-t Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): attending phy-23b. Did tobacco use contribute to the cause of death? signed by the a d be deteched f Pert II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ 34b. Were autopsy findings eveileble prior to completion of ceuse of deeth? 24a. Was an autopsy performed? Completed is certificate has be director, page 2 s 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No of Attending Physician: effer death. Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Ves 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Menner of Death 28b. Time of 28c. fnjury at Work? Certification: 1 Netural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be To the Hospital or Atte within 24 hours effer de To the Funeral Directo completely filled in by the 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Phyerclan: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and tille of certifier 29c. License number 00063612 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) N. MAIN St. Berlin, MD 21811 160f4 dra MAN

DHMH 16 Rev 6/95

State

Registrar

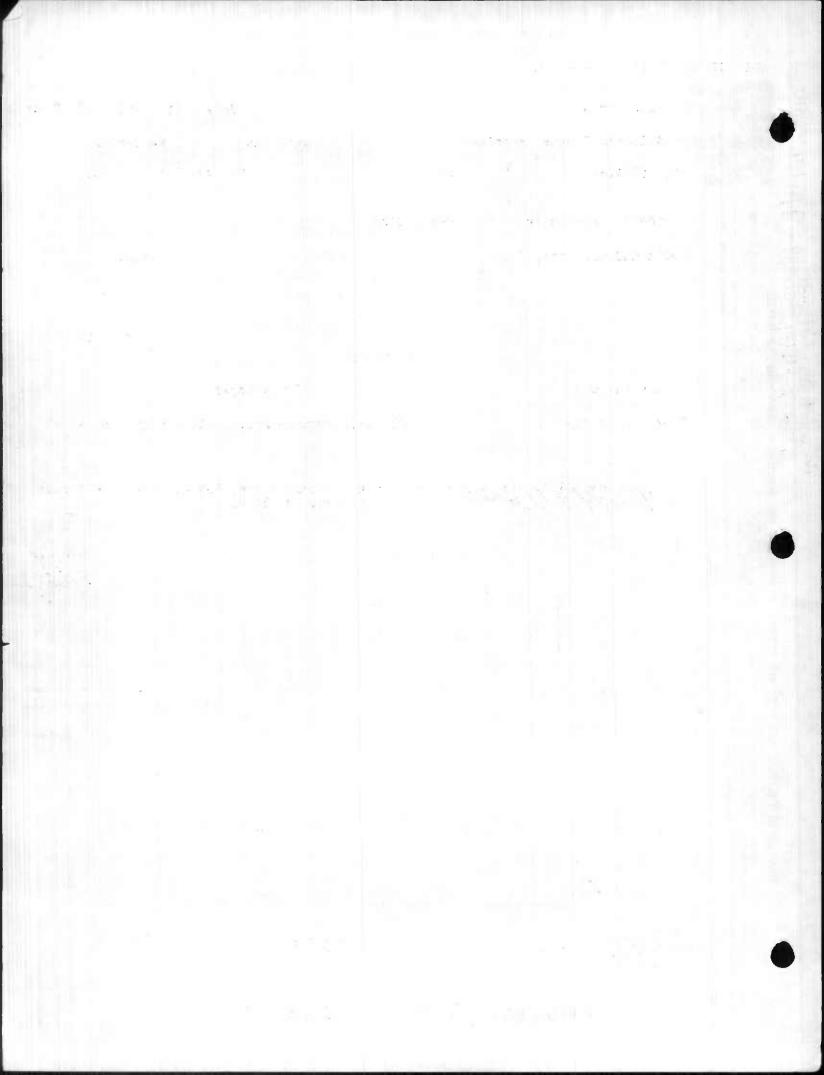
A # D

AUG 04

32. Registrer's Signature

1999

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 9 Certificate of Death Amended Item#3 perPhyG774 8/4/99 FW 1. Decedent's Neme (First, Middla, Last) 2. Data of Death July **Physician** Ora L. Brison 26 7;26PM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 2401 St Stephens Court Baltimore N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) **Funeral** Days Months Hours 1 M 200 F 83 248-34-5412 1-15-1916 Director Usual Rasidence of Decedent 10a. State 10c, City, Town or Location 10d. Inside City Limits 10b. County 1 ♥ Yas 2 No Directo Baltimore 28a-f 96 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8 8 21216 2401 St Stephens 4 23a Court USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Giva Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Bleck, White, etc. filed within 72 hours after 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes X ☑ No Specify: Specify: Black þ 3 Ø Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Businass/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th grade N/A 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumeme) Pages 1 and 2 should be fit ment of Health and Mental H ant: If tern 27 is marked oth lary or other traumatic event Be Willie Byers Elizabeth Foster 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) t9a. Informant's Name/Reletionship (Type, Print) York, S.C. 29745 Alaine Byers - Sister-In- Law 500 S. Congress Street 20a. Method of Disposition 20b. Place of Disposition (Nama of cemetery, cremetory or other place) Data 20c. Location - City or Town, Stata 1 Burial 2 □ Cremation 3 □ Removal from Stata 7-31-99 Baltimore, Md Woodlawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) lure of Funeral Service Libensee 22. Name and Address of Facility
March F/H West raun 4300 Wabash Avenue Baltimore, Md 21215 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, short, or him halture. List only one cause on ach line. Approximata Intarvat Between Onset end Death **Physician** /Medical Immediata Causa (Final ension disease or condition rasulting in death) Examiner The law requires that the death certificate be executed burial-transit Sequentially tist conditions, if eny, leading to immediata cause. Enter Underlying Cause (Diseese or injury that initiated events rasulting in death) Last Due to (or as a consequence of): pue Box 68760, Physician/Medical the Due to (or as a consequence of): for use Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I, 23b. Did tobacco use contribute to the cause of death? been signed by the Division of Vital Records, P.O. 1 Yee 2 No 3 Probably 4 Unknown Completed by 24b. Ware autopsy findings available prior to 24a. Wes an autopsy performed? completion of cause of death? page 2 1 Yas 2 No 1 □ Yas 2 □ No certificate or Attending Physician: funeral director, Be 25. Was casa referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yas 20 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1/Natural 2 Accident 5 Pending investigation 1 Yes 2 No 24 hours after death.

Funeral Director: A 6 ☐ Could not be 3 ☐ Suicide Location (Street and Number or Rural Routa Number, City or Town, Stete) 28e. Place of tnjury - At homa, tarm, street, factory, office building, atc. (Specify) filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the tima, date and place, and due to the causa(s) and manner stated. 29e. Cartifie (Check only one) within 2 94

State Registrar

31. Data tiled (Month, Day, Year) AUG 0

Rood clust eight work

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30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

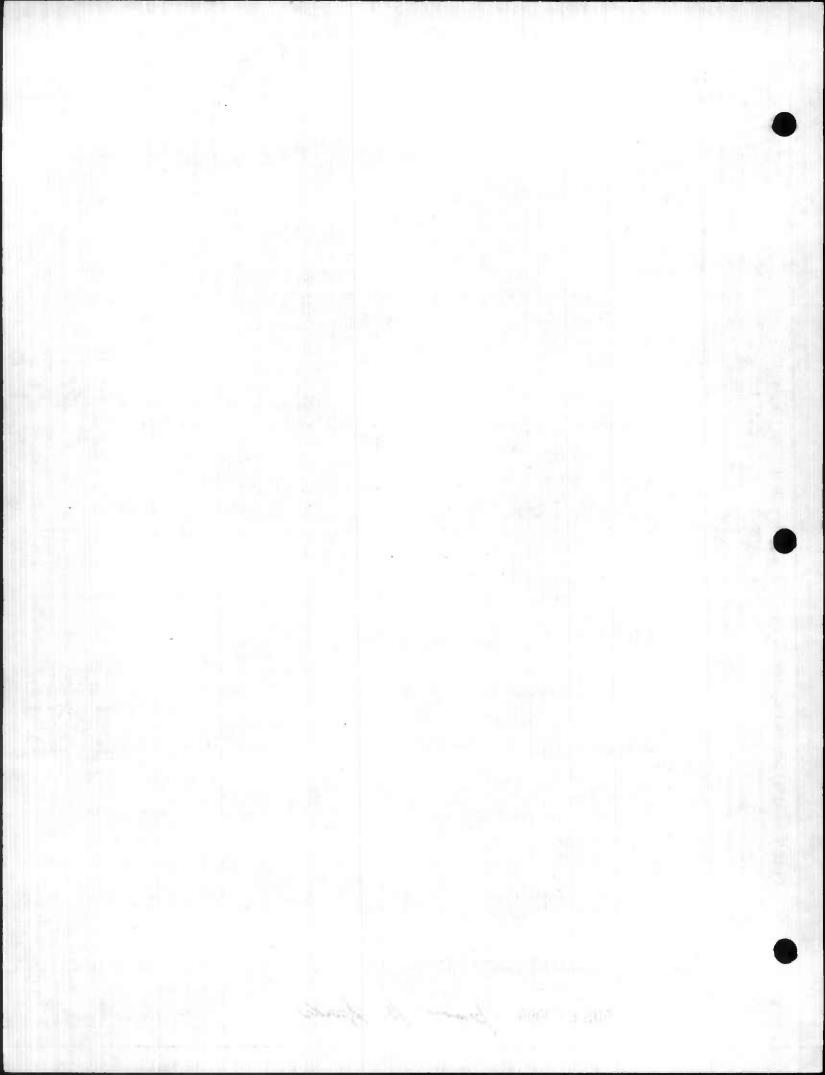
29b. Signature and titla of certifier

HOMAS 32. Registrar's Signature

M.D. 4000 W Northern M.D. 4000 W Northern

29c. License number

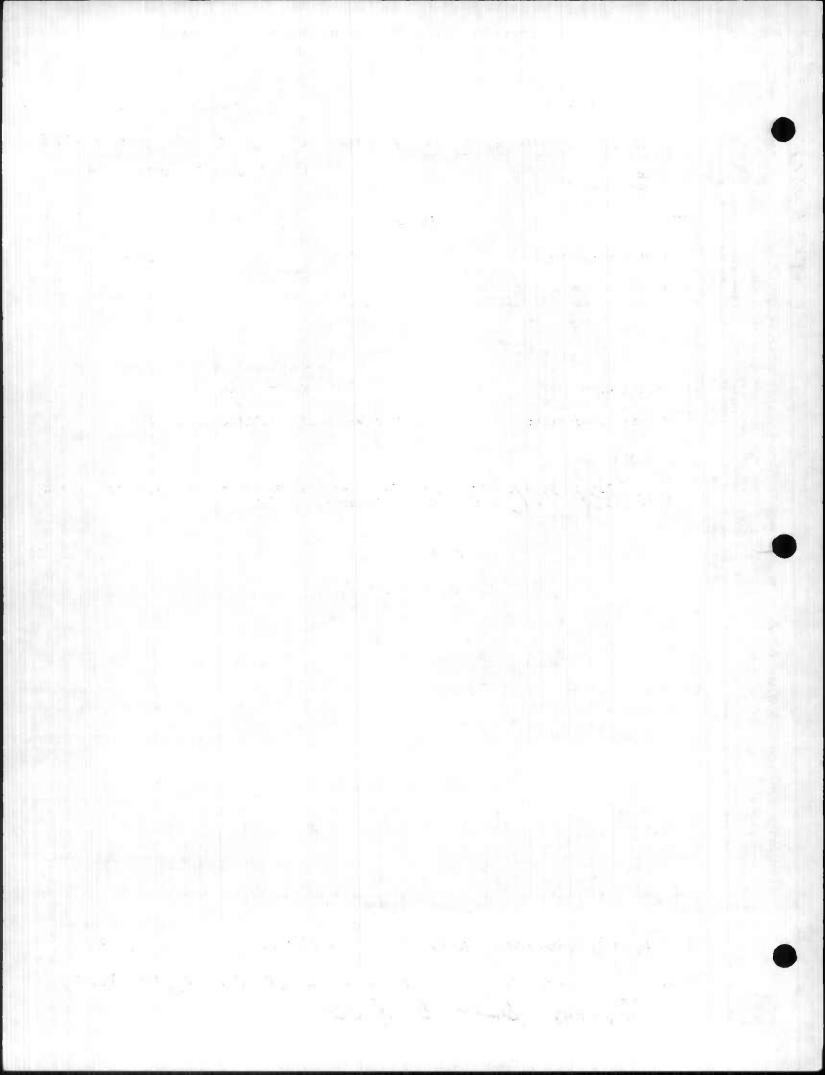
29d. Date signed (Month, Day, Year)



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riease Type or Prin	t in black indelible link.	Assure All Copies	Ale Legible

				Cei	tificate	of Death	7		Reg. No. 9	24	445		
1. Decedent's Name (First								2. Date of De Month	Day	Yeer	3. Time of Death		
ALL ALL	son Cal		6 - 4			4h City T	oum or le	JUNE ocation of Deat		999	3:32 PM		
4a Fecility Name (If not ins					1.20				-		10-16)		
FRANKLIN 5. Social Security Number	6. Sex	KIC HO	7. Age (In yrs.	last birthday	If Under 1 Y	ear If Unde	r 24 Hrs.	ALE 8. Date of Bir	rth T		e (State or Foreign		
none	1□	M 2∏ F		Yrs.	Months D	ays Hours 05	Min. 05	June 2	6, 1999	Country	2		
Usual Residence of Deced	-												
	County		10c. Cit	y, Town or Lo	cation					10d	I. Inside City Limits  1X Yes 2 □ No		
MD			Ва	1timor	7								
10e. Street and Number					10f. Zip Co								
1134 Newco		10 Mas Dass	dent Ever in U	C 12.1	21205		rioln? /Sn	ecify Yes or No	U.S.	A . e - American	Indian		
11. Maritei Stetus  12 Never Married 2[		Armed For	ces?	,3.	t Yes, specify	Cuban, Mexico	an, Puerto	Rican, etc.)	Blac	ck, White, etc	2.		
3 ☐ Widowed 4 ☐ Di		It Yes, Give Yeer or Da	е		1□Yes 2□ known	No Specify	y:		Specify: Black				
	cedent'a Educ			16a. Deced	dent's Usual O	ccupation	at at wart	Ina	16b. Kind ot B	usiness/Indu	stry		
Elementary/Secondery (	highest grade 0-12)	College (1	-4or 5+)	life. I	kind of work d DO NOT use re	etired)	ist of Work	my	-				
0				N	one								
17. Father's Name (First, A									, Maiden Sumen	16)			
Carlos Cab		5:0		400 84-10			yra (		City on Town	State 7in C	la da l		
19e. tntormant's Neme/Re Maryra Cab								timore,	MD 212		000)		
20a. Method of Disposition		EI	20b. F	Place of Dispo	sition (Neme o	of	рат	Date Date	20c. Location		n, State		
1 Burial 2 Crem 4 Domation 5 0	ation 3 R	emovel from S	State	cemetery, cren	netory or other	r place)							
21. Signature of Faneral S			Direct	or S	2. Name end A tate Ar altimor	natomy	Board		W. Balt:	imore	Street		
23a. Pert1. Enter the dise shock, or heert teilur	ase, or compli	cations that co	Bused the deet						arrest,	A	opproximete ntervel Between		
Spook, or need tends	s. List only of	10 02050 011 01	BOT INTO.							Ö	Inset and Death		
Immediate Cause (Finel disease or condition as PREMATURITY									10	HOURS			
Due to (or as a consequence of):													
Sequentially list conditions if any, leading to immediat cause. Enter Underlying	_ b	PRE	-TER	NL,	ABOR								
Sequentially list conditions if any, leading to immedial cause. Enter Underlying Ceuse (Disease or Injury	e e		Due to (d	or as a consec	quenca ot):					i			
cause. Enter Underlying Ceuse (Diseese or Injury that initiated events	< 0	÷	Due to 4		wanne of								
Ceuse (Disease or Injury that initiated events resulting in death) Last			Due to (d	or as e conseq	uence or):								
		J			-								
Pert II. Other significant c	ondittons con	tributing to de	ath but not res	ulting in the u	nderlying caus	se given In Par	t I.	23b. Dld	tobacco use co	ntribute to t	he cause of death		
					, ,			1 🗆	Yes 20 No	3 Proba	bly 4 Unknow		
								24e. Wes	s en eutopsy ormed?	avail	e autopsy tindings able prior to pietion of cause		
										of de	eth?		
								10	Yes 2. No	10	Yes 2□ No		
25. Was case reterred to rexaminer?		Inspital:				1	ce of Deat	th (Check only	one)				
1 ☐ Yes 2 ☐ No 27. Manner of Death				ER/Outpatier 28b. Time of			Nursing Ho		idenca 8 Oth				
1 Natural 5	Pending investigation	(Mont	ot Injury h, Day Year)	Injury	M 200.	Injury at Work? 1 Yes 2	□No	EUG. Describe	mon injury cocci				
2 Accident 3 Suicide 6	Could not be	28e. Piaca	ot Injury - At h	ome, tarm, str					(Street and Num	ber or Rural I	Route Number,		
4  Homicide	determined	buildir	ng, etc. (Specil	fy)				City or To	own, State)				
29e. Certifier 1 C C (Check only 2 M	ortifying Phya odicat Examir	ner: On the ba	isis of examina	owledge, deeth	n occurred at to vestigetion, in	he time, date a my oplnion, de	and placa, eath occur	and due to the	cause(s) end m , date and place,	anner as state	ted. he cause(s)		
27. Manner of Death 1 Natural 5   2	cartifier	and mann	ier stated.		29c. L	Icense numbe	r		29d. Date signe	ed (Month, Di	ay, Year)		
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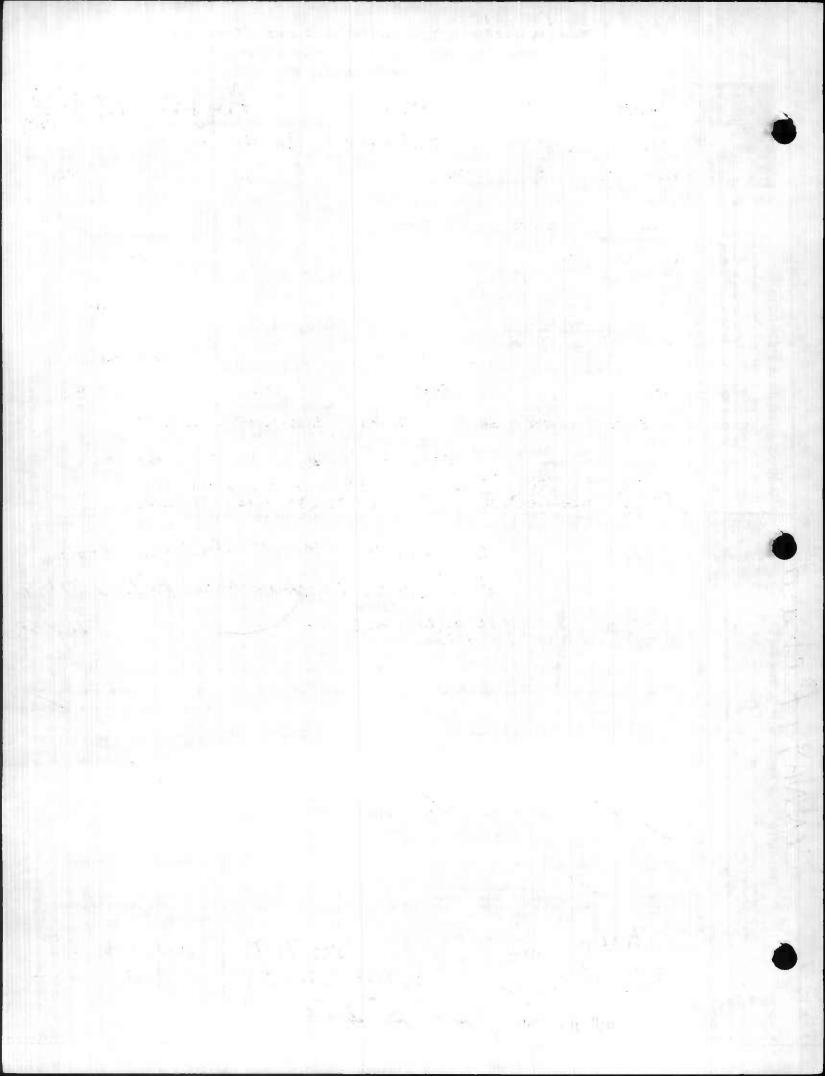
#### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1 Decedent's Name (First Middle Last) **Physician** CONWAY RTCHARD · /Medical 4b. City, Town, or Location of Deals Rm 4e Fecility Neme (If not institution, give street and number) Examiner Baltimore last birthday) If Under 1 Year Sinai 0+ Baltimore Spita If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (in yrs. last birthday) **Funeral** Months Deys Hours Min. 123 M 2□ F 218-01-8326 March 12, Md. **Director** Usual Residence of Decedent the Maryland r 28a-f show 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 K No Directo Baltimore Md. Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? with r than "natural", or Itams 23a or the Medical Examiner must be a 11 Burnbrae Rd. 21204 USA d 2 should be filed within 72 hours efter death th and Mental Hygiene. 7 is marked other than "naturel; or items 23. transmits avent, the Medical Examples of the manual content of the co Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Rece - American Indian 11. Maritel Stetus Bieck, White, etc. 1 X Yes 2 No If Yes, Give Yeer or Dates: WW-II 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: à 3 ₩idowed 4 Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Officer 0 James Walker Co. 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Conway Barbara Gallaher Thomas 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. informent's Name/Relationship (Type, Print) permit. Peges 1 end 2 sh Department of Health and Important: If Item 27 is m any Injury or other traum P.O. Box 475 Spotsylvania, Va. 22553 Ms. Patricia Conway/daughter 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Buriei 2 ☐ Cremetion 3 ☐ Removel from State 8/4/99 4 ☐ Donetion 5 ☐ Other (Specify) Hilltop Service Corp. Towson, Md. 22. Name end Address of Fecility Ruck Towson Funeral Home, Inc. 21. Signiffers of Foneral Service Licen-1050 York Rd. Towson, Md. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due 6 for es e consequence ot): vid Ange Chicric Genel friline Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Lest you fens on one (or es e consequence of): Box 68760, Physician/Medical 23b. Did tobacco usa contribute to the cause of degth? Pert II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Pert i. 1 Yes 2 No 3 Probably 4 Unknown signed t Ď 24b. Were autopsy findings eveilable prior to 24e. Wes en eutopsy performed? Completed completion of cause of deeth? 1 Yes 2DNo 1 ☐ Yes 2 ☐ No 25. Was case referred to predical examiner? Be 26. Plece of Deeth (Check only one) 70 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Dutpetient 3 DOA 1 Yes 2 No 1 Inpatient 28e. Dete of Injury (Month, Dey Year) 27. Menper of Deeth 28d. Describe how injury occurred 28b Time of 28c. injury et Work? Certification: Naturai 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piaca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 8 24 hours Funeral 29a. Certifier 🖆 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Dete signed (Month, Day, Year) 29b. Signaturg and title of certifier 29c. License number o completed cause of deeth (item 23e) (Type, Print) 30. Neme end eddress of parts where and

32. Registrer's Signeture

DHMH 16 Rev 6/95

Registrar

31. Dete filed (Month, Day,

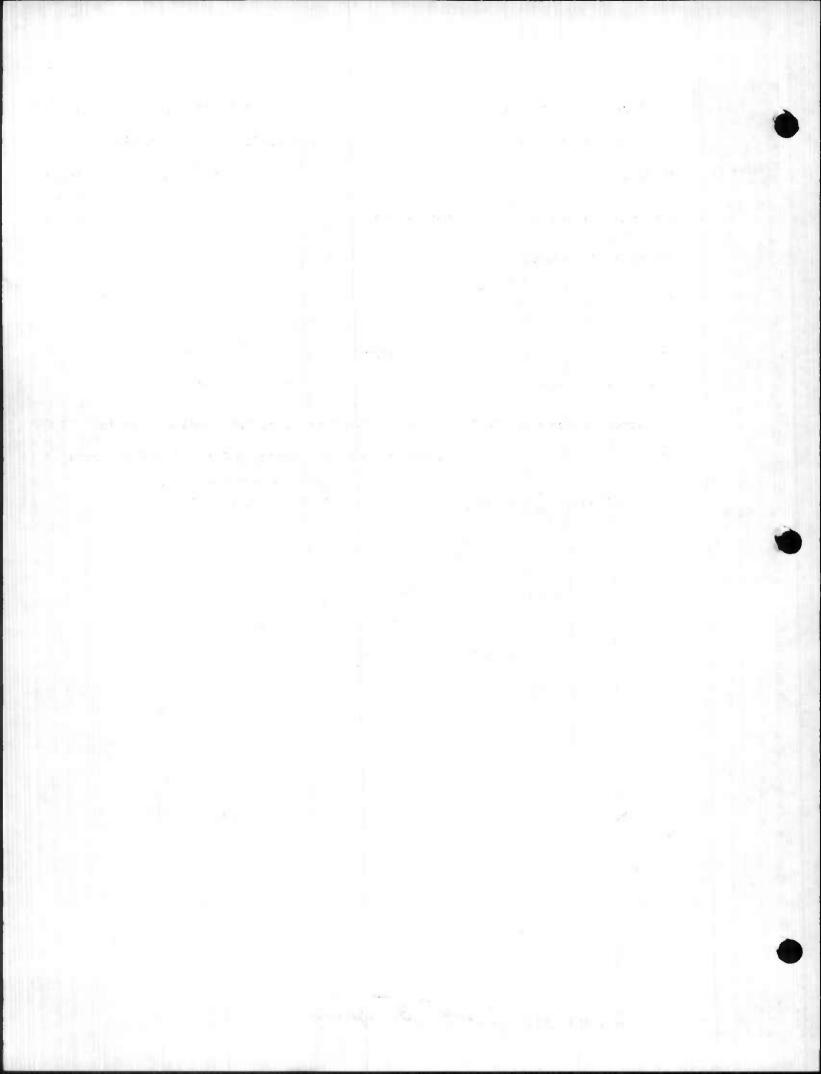


## Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3 Time of Death Month **Physician** C. Carouge 1999 July 31, 8:00 AM /Medicai 4e. Fecility Nama (If not institution, giva street and numbar) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** 125 Orthoridge Road Lutherville Baltimore 5. Sociel Sacurity Number If Undar 1 Yeer If Under 24 Hrs. 6 Sax 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funerai** 1₽M 2□F Months Days Hours Yrs Director 203-22-2958 69 10-29-1929 Pennsylvania Usuel Rasidanca of Dacedani the Maryland 10e Stata 10b. County 10c. City, Town or Location 10d. Inaida City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yas 2 ☑ No Director Maryland Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 6 filed within 72 hours after death with Нета 23а Funeral 125 Orthoridge Road S . A . 14. Raca - American Indien, Black, White, atc. 21093 12. Was Dacedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Detes: Was Decadent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 1 Naver Marriad 2 Married ŏ 21215-0020 1 ☐ Yas 2 ☐ No Specify: Specify: White þ **¾**□ Widowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grade complated) 16b. Kind of Buainass/Industry pernit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene Important: If Item 27 is marked other than eny Injury or other traumatic event. Elementary/Secondery (0-12) Collega (1-4or 5+) Homemaker Own Home Baltimore, Maryland 17 Fathar's Neme (First Middle Last) 18. Mothar's Nama (First, Middla, Meldan Sumama) Be Thomas Hoover Dietrich 2 Anna 19a. Informant's Neme/Ralationship (Typa, Print) 19b. Mailing Addresa (Straat and Numbar or Rural Route Number, City or Town, Stata, Zip Coda) Mr. Wayne D. Carouge (Son) 125 Orthoridge Road, Lutherville, Maryland 21093 20b. Placa of Disposition (Nama of camatary, crematory or other placa) 20a. Mathod of Disposition Date 20c. Location - City or Town, Stete 1 ₺ Burlel 2 Cramation 3 Ramoval from Stata Dulaney Valley Mem. Gards. 8-7-99 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Spacify) 21 Signature of Funeral Sarvice Licensea 22. Nama and Addrass of Facility
Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. h. Do not anter the moda of dying, such es cardiac or respiretory arrest, Approximate Intarval Batween Onset and Death **Physician** /Medical Immediate Causa (Final 6 disaasa or condition rasulting in daath) Examiner (or as e consaquance of) n The law requires that the death certificete be executed Sequantially list conditions, if any, laading to immadiata cause. Entar Undarlying Causa (Disaasa or Injury thet initiated evants rasulting in death) Lest Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ettending physician Physician/Medical Dua to (or es a consaquanca of): Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? the th signed by t 2000 3 Probably 4 Unknown 1 Yes þ Completed 24b. Wara autopsy findings aveilable prior to 24a. Was an autopsy performed? peen completion of cause of daath? has 200 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica Be 25. Wea casa rafarred to medical 26. Pleca of Death (Check only one) axaminar? Othar: 4 Nursing Homa 5 Rasidence 8 Othar (Specify) 30 No 2 1 Yas 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA 28c. Injury et Work? 28d. Describe how injury occurred Certification: 27. Mennar of Deett 28a. Data of Injury (Month, Day Year) 28b. Time of Natural 5 Panding invastigation 1 Tes 2 No Accidant 6 Could not be datermined 3 Suicida 28f. Location (Straat and Number or Rural Route Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify) in by 4 Homicide within 24 hours a 29a. Certifier Cartifying Physictan: To tha best of my knowledge, daeth occurred et the time, dete end plece, and dua to tha cause(s) and mannar as atated. Medical 2 Medical Examinar: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, dete end pleca, and due to the cause(s) and manner stated. ş 29b. Signatura and title of confirm 29c Licensa number 29d. Data signed (Month, Day, Year) 30. Name and address of person wi completed causa of daath (ttam 23a) (Type, Print) W. HAUPTMAN, M.D. 6565 N. CHARLES 51. BALTO HOWARD 31. Data filad (Month, Dey, Yaer) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

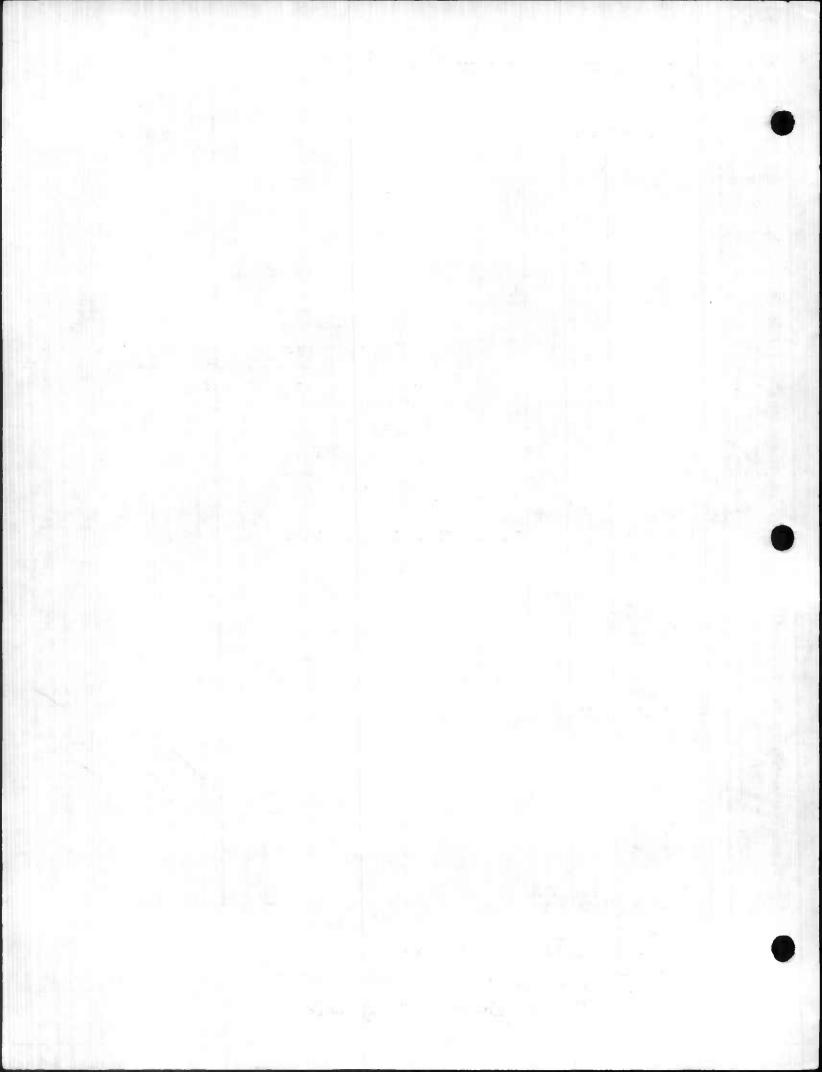


## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O. O.

	ECKERT AMEND ITE		,,	LINOGILI	ilcate of	Death	2. Date of De	Reg. No. ath	3.	Time of Death			
Physician	Gerald A. Dec						Month JULY	Day 28, 199	Year	1348 PI			
/Medical Examiner	4e Facility Name (If not institu	ition, give street and numb				4b. City, Town, or	Location of Deeth	4c. County	of Death				
	5. Sociel Security Number	COUNTY HOSP:	. Age (In yrs. la	et hirthday)	f Under 1 Yeer	HAGERST			INGTON	/State or Famina			
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Dire	10e. Street and Number 6075 Claire [	ni vo			10f. Zip Code 21075			10g. Citizen of V					
r News 23a or 23a-f s direc must be notified Funeral Director	11. Merital Stetus	12. Wes Deced	ent Ever in U,S	6. 13. We		lispanic Origin? (S an, Mexican, Puer	pecify Yes or No	USA 14. Rec	e - American Ir	ndien,			
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is certificate has be director, page 2 a	25. Was case referred to med exeminer?  XIX Yes 2 □ No	Hospital:	ation XPV-	'D/O	all post Oth	er.	eth (Check only o		(0				
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DHMH 16 Rev 6/95

Registrar



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** MARJORIE DALLAM 29,1999 JULY 6:30 AM /Medical 4a. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** 700 NORTH CHARLES STREET BALTIMORE If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5 Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Deys 1□ M**X2X** F 147-16-3899 Yrs. 79 08-05-1919 Director VIRGINIA Usuel Residence of Decedent filed within 72 hours efter death with the Maryland 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f short trust be notified at MD. N/A BALTIMORE CITY XIX Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 700 NORTH CHARLES STREET 21201 U.S.A. Completed by Funeral 14. Race - American Indien, Bleck, White, etc. 11. Meritel Stetus 12. Wes Decedent Ever In U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filled within 72 hours efter de nent of Health and Mentel Hygiene. Int: If Itan 27 le merked other than "naturst", or Itam Iny or other traumatic event, in Andrial Enail iner. 1 ☐ Yes XXNo If Yes, Give Year or Dates: 1 Never Merried Married Baltimore, Maryland 21215-0020 1 ☐ Yes XX No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grade completed) TEACHER VOICE College (1-4or 5+) Elementary/Secondary (0-12) VOCAL AND SOLOIST TEACHER 2 YEARS 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Be **OSCAR** LEHMANN GLADYS FRENCH 19a. informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROUSE FREELAND 2300 EAST EAGER ST., BALTIMORE, MD., 21202 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 Cremetion 3 Removel from State permit. Pege Department o Important: If any Injury or CHURCH OF ROCK SPRINGS 8-1 FOREST HILL, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licanses 22. Name end Address of Fecility
HENRY W.JENKINS AND SONS COMPANY R. G. Ruta 4905 YORK ROAD, BALTIMORE, MARYLAND, 21212 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. **Physician** Right Hemostrhagic Stroke 2 mon

Due to (or es e consequenca of):

AtheroSclerotic Vascular disease 10 yr /Medical Immediete Cause (Finel disease or condition resulting In death) Examiner Examiner The law requires that the death certificate be executed buriel-transit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest pue Box 68760, Physician/Medical phys. Due to (or es e consequenca of): 80 use been signed by the e should be deteched for P.O. Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobseco use contribute to the cause of desth? 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were sutopsy findings eveileble prior to completion of cause of desth? Completed 24a. Wes an autopsy page 2 1 Yes XXNo 1 Yes 2 No of Vital Hospital or Attending Physician: director, 25. Wes case referred to medical Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home XXResidence 6 Other (Specify) 1 ☐ Yes XX No Certification: To this funeral 28e. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? After Division 5 Pending Investigation XX Natural efter death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours of To the Funeral D completely filled i 12 Certifying Physicisn: To the best of my knowledge, death occurred at the time, date end piaca, end due to the ceuse(s) end menner ss steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and piace, and due to the cause(s) end menner steted. 29a. Certifier Medical

31. Dete filed (Month, Day, Year) State AUG 0 4 1999 Registrar

29b. Signeture end title of certifier

SAMARA, M.D., 3333 N.CALVERT ST., BALTIMORE, MARYLAND, 21218 32. Registrer's Signeture

Danala, M.D.

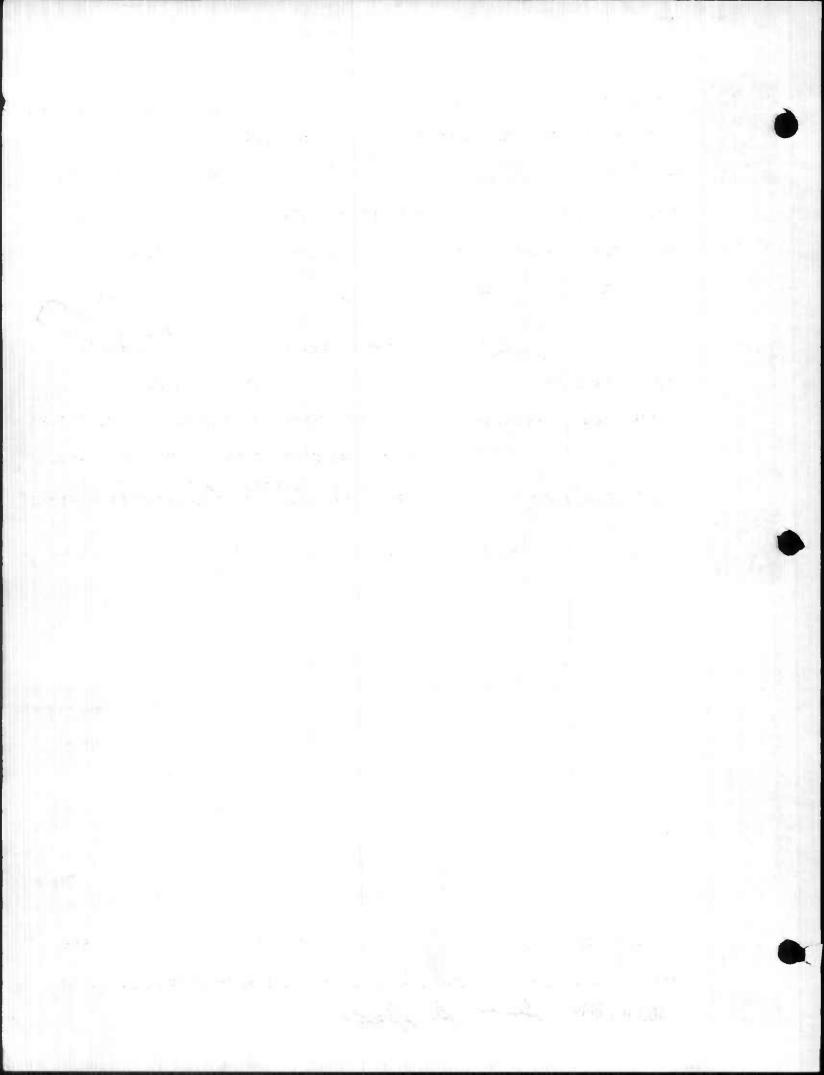
30. Name end address of person who completed cause of death (Item 23e) (Type, Print)

29c. License number

052016

29d. Dete signed (Month, Day, Year)

JULY 29, 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death 1 Decedent's Name (First, Middle Last) Month Day **Physician** )ZIKIP PUSKI 1999 29 1035 AM JUL /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner 3ALTIMORE If Under 24 Hrs. 8. Date of SINAI MOSPITAL OFBALTIMORE If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Days Hours Min 276-03-7010 Usuel Residence of Decedent 76-03-7016 Makuland Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits s 1 and 2 should be filed within 72 hours after death with the Maryle if Health and Mentel Hygiena. If Health and Sa or 28e-f ehow other traumetic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Md 10f. Zlp Code 10g. Citizen of What Country? 10e. Street end Number 21234 3316 WHE Kd Funeral 12. Was Decedent Ever In U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Meritel Stetus 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: White Specify: by 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) GENERA Maryland Elementery/Secondary (0-12) College (1-4or 5+) NURSE KIELEWSKI, ANNE Lol 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) To Be harles -/ICKINGER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 les PLAGU A
20a. Method of Disposition 3316 20c. Location - City or Town, Stele 20b. Place of Disposition (Name of cemetery, crematory or other place) Aug. 2 1 Burial 2 Cremetion 3 Removal from State
4 Donation 5 Other (Specify) 22. Name and Address of Facility Funeral Chapel Hartord 236. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 1LROSEYSIS 5 DAYS **Examiner** Examiner ACUTE RENAL

Due to (or as e consequence of): FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest METABOLIC ACIDOSIS

Due to (or as a consequenca of): P.O. Box 68760, Physician/Medical DEMYDRATION Pert II. Other algrifficant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown INSULIN DAPENDENT DIABETES MELLITUS Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? GOUT cartificata has b lirector, page 2 sl 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Wes case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA this 27. Menner of Death 28h. Time of 28d. Describe how Injury occurred 28c. Injury et Work? Certification: Hospital or Attending Natural 5 Pending investigation 1 Tyes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide 24 hours Lecrifying Physicien: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hou To the Fune completely fi edical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

SINAL HOSPITAL OF BALTIMORK 32. Aegistrer's Sigr 31. Date filed (Month, Dey, Year) AUG 0 4

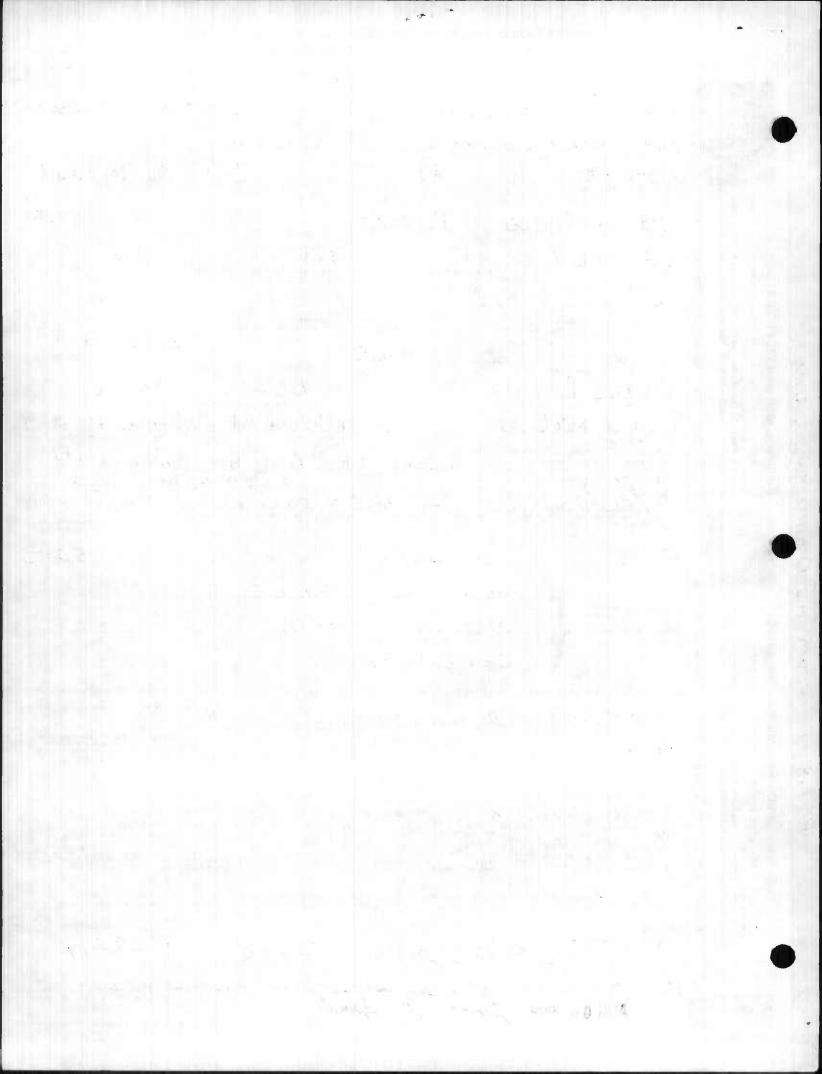
30. Name and address of person who completed cause of death (Ifem 23e) (Type, Print)

WESELVEDERE AVE, BALTIMORE, MD 21215

**DHMH 16 Ray 6/95** 

KNONY

PATIENT



1. Decedent's Neme (First, Middle, Last)

Gilchrist Center

4a. Fecllity Neme (If not institution, give street end number)

PARKS

1□M 2∯F

ELIZABETH

241-86-2839

Usuel Residence of Decedent

ŏ items 23a traumatic event, the Medical Examiner 0 permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "netural", any Injury or other traumatic event, the Medical Exa

August 2,1999 c 12:25 pm

**Physician** 

for use as Records, 8 Division of Vital To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certified completely filled in by the funeral director; it

10a State 10b. County 10c. City, Town or Location Director **Baltimore** Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? USA 21212 Funeral 7002 Kenleigh Rd. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Maritel Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: ρX 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Family Therapist Therapy 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Darnell Parks Rebecca William Brett 19e. Informent's Neme/Retetionship (Type, Print) 19b. Meiting Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 7002 Kenleigh Rd. Baltimore, Md. 21212 Mr. David Dishler/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1 Buriel 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 8/4/99 Parkville, Md. Parkwood Cemetery 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD. 21204 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Breast concer Immediate Ceuse (Finel disease or condition resulting in death) Examiner Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Physician/Medical Due to (or es e consequence of) Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the ceuee of deeth? 1 Yee 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to 24e. Wes en eutopsy Completed 1 Yes 2 No 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Hospitet 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice 1 Yes 2 No 27. Manner of Deeth 28d. Describe how Injury occurred 28b. Time of Medical Certification: 5 Pending 120Naturel 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the ceuse(s) end menner steted. 29e. Certifier 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles St. Halto. Md 2(20)

GBM (

32. Registre s Signeture

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death

If Under 1 Year

Deys

DISHLER

Yrs.

7. Age (In yrs. last birthday)

51

2. Dete of Deeth

4b. City, Town, or Location of Deeth 4c. County of Death

Towson
If Under 24 Hrs.
Hours Min.

August 2, Dey 1999 Yeer

8. Dete of Birth Sept. 10, 1947

**Baltimore** 

3. Time of Deeth

Birthplece (Stete or Foreign Country)

10d. Inside City Limits 1 Yes 2 No

Onset end Death

Lyenvs

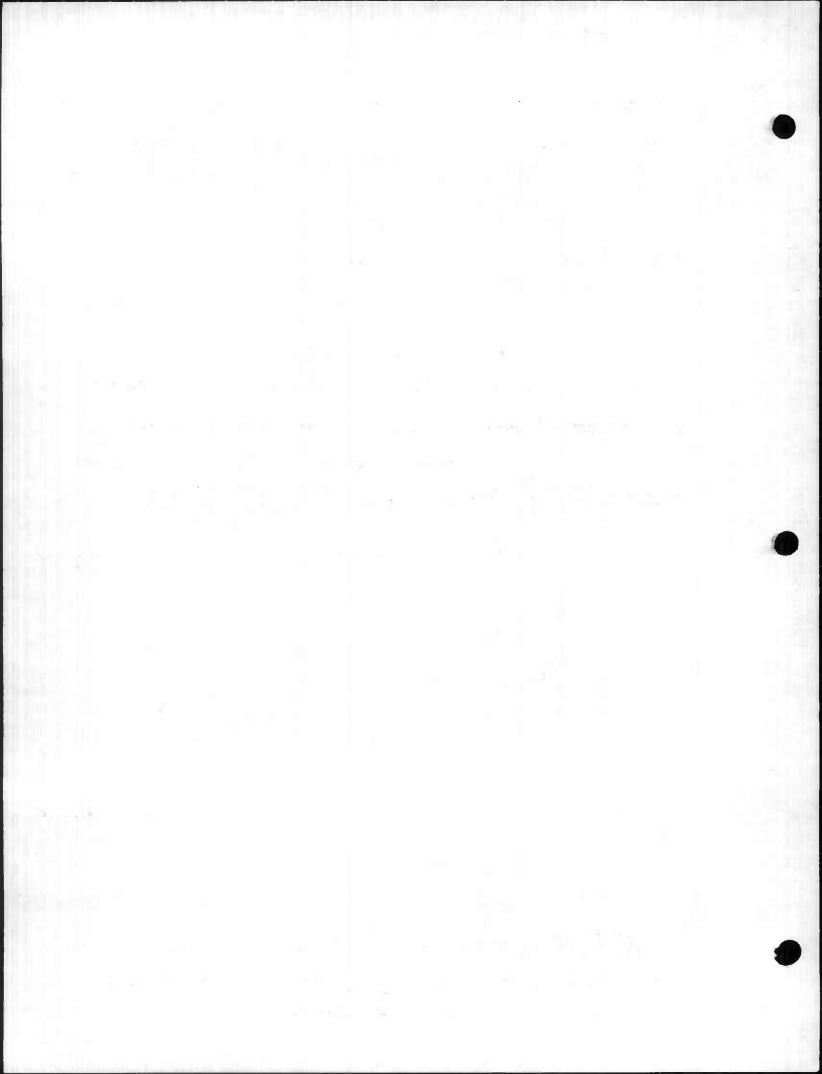
completion of cause of death?

1 ☐ Yes 2 ☐ No

12:25 PM

Registrar

31. Dete filed (Month, Day, Year)



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No. 9 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Dey Month **Physician** Thelma Dunbar 30,1999 July 6:00 P.M. /Medical 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner Prince Georges Hospital Center Cheverly Prince Georges If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Yeer) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** Days 1 □ M 2X F Yrs. 78 May 12,1921 Virginia Director 225-24-6756 Usuel Residence of Decedent with the Meryland r 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince Georges Capitol Heights 1 Yes 2 XNo Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be r 6813 Drylog Street 20743 IISA permit. Pages 1 and 2 should be filed within 72 hours aftar death v Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23s any injury or other traumatic event, in a Medical Exercise mail Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Rece - American Indian 11. Marital Stetus Bleck, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 XNo Specify: Specify: Black by 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home 3rd Home Maker 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Tommie Garner Edna Williamson 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 20743 19e. Informant's Name/Reletionship (Type, Print) Leon Dunbar -Son 6813 Drylog St.Capitol Heights, Maryland 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 8/4/99 1 Burial 2 ☐ Cremation 3 ☐ Removel from Stete Annandale, Va. 4 ☐ Donation 5 ☐ Other (Specify) Pleasant Valley Mem.Pk. 22. Name and Address of Facility Chinn Funeral 21. Signeture of Funeral Service Licenses Service 2605 S.Shirlington Rd.Arl., Va. 22206 15 23a. Part1. Enter the disease, or complications that caused the seth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximate Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) RIEUMSNIM Examiner Due to (or as a consequence of) Examine CHF physician and the burial-trensit The law requires that the deeth certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury Due to (or as e consequence of): - M. TYPE Box 68760 Physician/Medical that initieted events resulting in death) Last Due to (or es e consequence of): as POXOEMIA attending use. 23b. Did tobacco use contributa to the causa of death? o the Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by the 1 ☐ Yee 2 ☐ No 3 ☐ Probabiy 4 ☐ Unknown م Records, 2 24b. Were eutopsy findings available prior to 24e. Wes en autopsy Completed peen completion of ceuse of death? has ebed 1 Yes 25 No 1 ☐ Yes 2 ☐ No certificata Division of Vital or Attending Physician: Be 25. Was cese referred to medical exeminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2N No 1 Inpatient 2 ER/Outpetient 3 DOA this funerel 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? After 5 Pending 1 Natural n 24 hours eftar death.

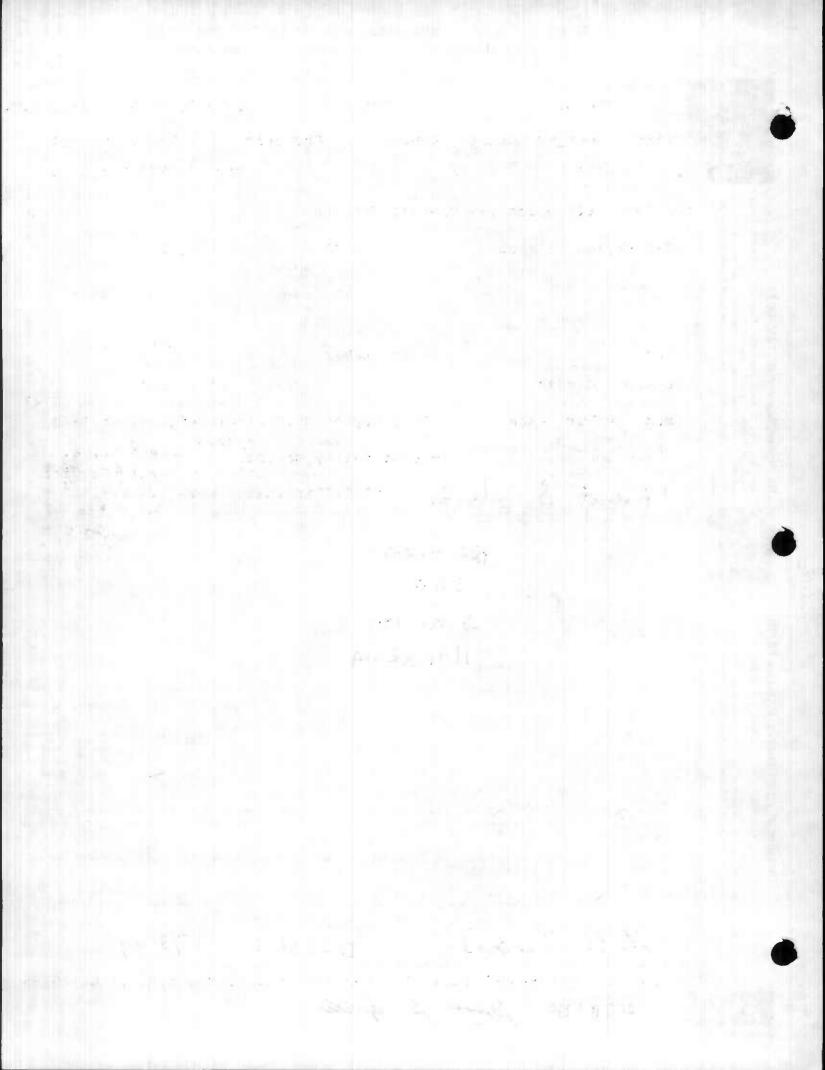
e Funeral Director: After detaily filled in by the fur 1 Yes 2 No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Cartifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner steted. edicai 29a. Certifie (Check only one) within 2 the state 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 0 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) Ophne11 Cumberbatch M.D. 8614 Central Ave. Landover, Maryland 20785

AHC

State Registrar 31. Date filed (Month, Dey, Year) AUG 0 4 1999 32, Registrar's Signature

Sporks



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First Middle, Last) 2. Dete of Deeth TWLY, 30, 1999 FOWLER **Physician** 9:30 PM /Medicai 4e. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth **Examiner** HOSPITAL BALTIMORE HOME NIA If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey. 03 - 19 5. Sociel Security Number 7. Age (In yrs. last birthdey) Birthpleca (Steta or Foreign Country) **Funeral** 10 M 20 F 212.36.235 94 Yrs. Director Usuel Residence of Deceden the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits If flem 27 is marked other than "natural", or itsms 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at 1 Nes 2 No Director BALTIMORE MO NIA 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? MARKWAY 1010 WILDWOOD USA Funeral death 12. Was Decedent Ever In U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) Raca - Americen Indian, Black, Whita, atc. 11. Marital Stetus filed within 72 hours efter Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Dates: 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: BLACK þ 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withir Department of Heelith and Mantal Hygiene. Important: If fem 27 is merked other than any Injury or other traumetic avent Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC NIA 8 TH GRADE HOME 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Surnema) JOHN JOHNSON MAGGIE JOHNSON 19e. Informent's Neme/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 1010 WILDWOOD HRWY, DAUGHTER BALTO. MD. VIOLA WILSON 20e. Method of Disposition 20b. Pleca of Disposition (Name of cemetery, cremetery or other place) Dete 20c. Location - City or Town, Stete 1 ☑ Burlal 2 ☐ Cremation 3 ☐ Removel from State 8.5.99 RANDAUSTOWN, MD KING MEMORIAL PARK 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Addrass of Facility VAUGHN C. GREENE FUNERAL SERVICE 23a. Pert 1. Enter the disease, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac of respiratory errest, shock, or heart influer. Lint only one cause on each line. **Physician** · CEREBRO VASCULAR ACCIDENT /Medical tmmediete Ceuse (Finel diseese or condition resulting in deeth) Examiner Due to (or es a consequence of):
HYPERTENSIVE VASCULAR DISEASE Physician/Medical Examiner Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that Initiated events resulting in deeth) Lest and Box 68760, physician Due to (or es e consequence of): P.0. Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown be det Records, þ 24b. Were autopsy findings avelleble prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? cartificata 1 Yes 2 11 No 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cardifica completely filled in by the funaral director; I Be 25. Was cese referred to medicel exeminer? 28. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Rasidence 8 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 1 PNaturet 5 Pending investigetion 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e Certifier 29b. Signeture end title of cartifier 29c. License number 29d. Dete signed (Month, Dey, Year)

State Registrar

32. Registrer's Signeture

Norsenn 30. Name end eddress of person who completed cause of deeth (ttem 23e) (Type, Print)

011322

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24454 Certificate of Death AMENDED ITEM #1 PER MD 8/4/99 AH 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month **Physician** /Medical 4a. Fecility Name (If not institution, give street and number) 4b. Clty, Town, or Location of Deeth 4c. County of Deeth Examiner Good Samaritan Hospital Baltimore N/A7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number if Under 24 Hrs. Birthplece (State or Foreign Country) 8. Dete of Birth (Month, Dey, Yeer) **Funeral** 1□ M 20 F Months Deys Hours 214-20-1740 Yrs. Director FEB 20, 1910 Pennsylvania Usuel Residence of Decedent the Meryland 10e Stete 10b County 10c. City, Town or Location 10d. Inside City Limits "natural", or hams 23s or 28s-f show 1 ☐ Yes 2 No Director Maryland Baltimore Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? death with 6401 Loch Raven Boulevard, Apt. 527 21239 USA 12. Wes Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. d 2 should be filed within 72 hours after of the and Mental Hygiene.
77 is marked other than "natural", or flait traumatic event, the Medical Examinal 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify: White þ 3 N Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) 10 Salesperson Clothing Store 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) . Peges 1 and 2 should be filt ment of Health and Mental Hant: If them 27 is marked oth jury or other traumatic even Be Charles Luers Pauline Berslicher 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Leslie F. Fewster/Nephew 1035 Breezewick Road Towson, MD 21286 20b. Placa of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State Important: If it any injury or o 1 ☐ Burlel 2 【Cremetion 3 ☐ Removel from State **Department** 5 ☐ Other (Specify) 4 Donetion Metro Crematory, Inc. 8/2/99 Baltimore, MD 22. Name end Address of Fecility Cremation Society of MD, Inc. 21. Signature Coneral Servi Edward gordhik 299 Frederick Road Baltimore, MD 21228 23e. Pert1. Enter the disease of complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. Unit only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final CHRONIC OBSTRUCTIVE PULMONARY DISGIST diseese or condition resulting in death) Examiner Due to (or es e consequence of) Examiner ALLURE THRIVE 70 burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) physician s the burial P.O. Box 68760. Physician/Medicai Due to (or es e consequenca of): 98 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown 1 ☐ Yss 2 ☐ No Records, þ 9 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? page 2 1□ Yes 2 No 1 Yes 2 No certificate Division of Vital Hospital or Attending Physician: 24 hours efter death. Funeral Diractor: After this certifica itely filled in by the funeral director, I Be 25. Wes case referred to medicel 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ PR/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 28e. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Sulcide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 - Homicide To the Hospital within 24 hours e To the Funeral C completely filled i 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete and plece, and due to the cause(s) and menner stated. edical 29a. Certifier 29b. Signature and title of certifie 29c. License number 29d. Dete signed (Month, Dey, Year) 52228

State Registrar

3007, E NORTHERN PKWY, BALTIMORE, MD 21214 IPULKUMAN SHAZODIYA 32. Registrer's Signature

30 Neme end address of person who completed cause of death (Item 23a) (Type, Print)

4 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMENDED ITEM #23a PART I & II PER MD G774 8/4/99 AH Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Date of Death Day Month Year **Physician** FORD 1999 RONALD 12:45PM JULY26, /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours 52 213 46 2091 Director Aug. 18,1946 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits rithen "neturel", or items 23s or 28s-1 ehorems the Medical Examiner must be notified at Maryland n/a Baltimore 1 XYes 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 2423 Chesterfield Ave. 21213 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ď No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Marital Status Black, White, etc. 1 Never Married 2 Merried 1 Yes 2 No Specify: Baitimore, Maryland 21215-0020 White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mentel Hygiens. Important: If Item 27 is marked other than \*1 eny Injury or other traumatic event. In a marked of the traumatic event. In a market tha Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) 12 Police Officer Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 Francis Snead Ford Muriel Clark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) Mary Ford / Wife 2423 Chesterfield Ave., Baltimore, MD 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State Green Mount Crematory 7/29/99 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 22. Name and Address of Facility
CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, 21286 MD 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset and Deeth Physician /Medical Immediate Cause (Final munediate disease or condition resulting in death) Examiner arle Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): and physician at the burial Box 68760. Due to (drias a consequence of) Aailu edical Physician/M HIV INFECTION 23b. Did tobacco use contribute to the cause of death? Part II. Other stanificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records. P.O. 1 Yes 2 No 3 Probably 4 Unknown DIABETES MELLITUS þ 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 2 NO 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Netural 2 Accident 5 Pending Ne Hospital or Attending in 24 hours after death. Ne Funerel Director: After 1 Yes 2 No investigation 8 Could not be 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the 29a. Certifier odical (Check only one) iner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. To the F 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier ratifola H. So, no 7/26/1999 026250 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

AUG 0 4 1999

MATILDA

31. Date filed (Month, Day, Year)

H.

GBMC 32. Registrar's Signature 6700 N. Charles St. Baltimore, MD. 21204 oaks

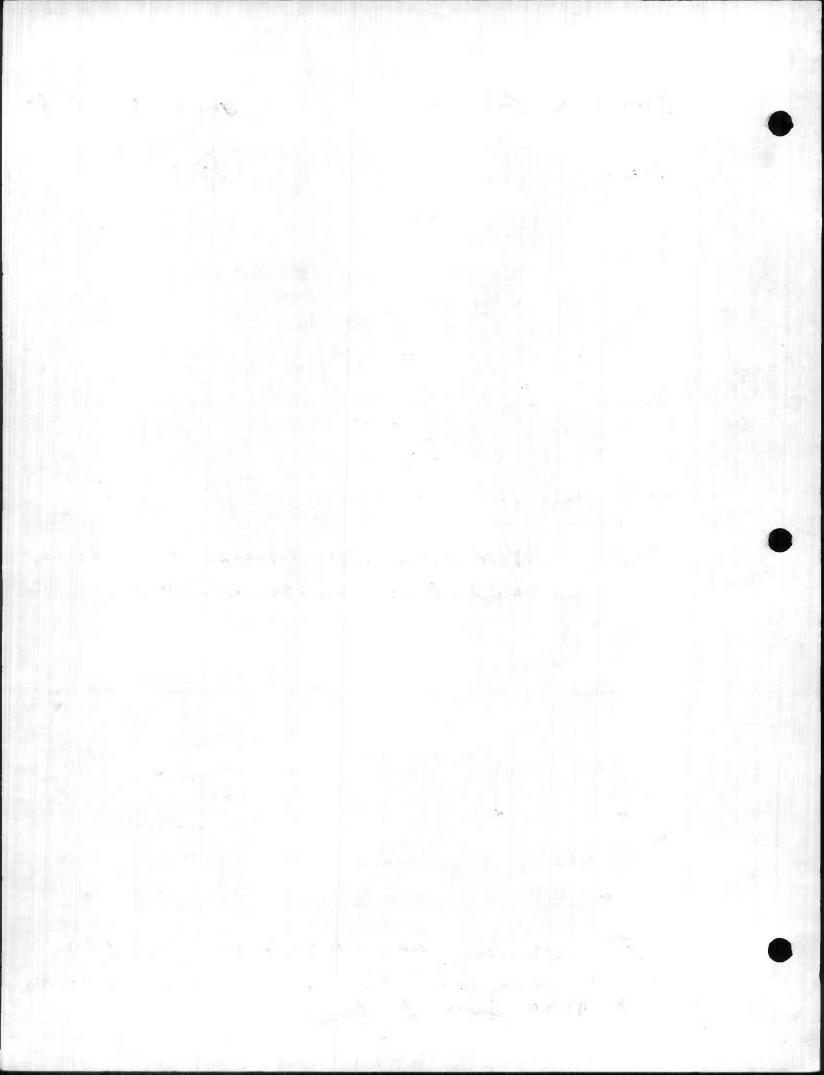
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## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					Certifica	ate of	Death		Reg. No.	244	56	
Physician	1	t's Name (First, Middle,	Last) GR	EEN	'E			2. Date of De Month	ath Day	Year	ime of Death	
/Medical Examiner	4a Facility	Neme (M not institution, sod Samarit	live street and number	)			4b. City, Town, or Balti	Location of Deat	-	-		
Funeral Director	240-	-41-6718 dence of Decedent	XIXM 2FF							Country)	State or Foreign	
land tand	10a. State	10b. County		10c. City, Town or Location					10d. Inside City Limits			
Man and and and and and and and and and a	MD	N	A	Baltimore						1 Yes 2 No		
th with the Mar 23a or 28a-f al ast be northed	10e. Street 43]	and Number . Notre Da	me Lane	101. Zip Code 1e Lane 21212			2		10g. Citizen of V USA	Citizen of What Country? JSA		
72 hours effer death with the Manyland natural; or Itema 23e or 28e-f ahow at a Examiner must be nortified at sted by Funeral Director	3 Wid	Stetus er Married ★☑ Married lowed 4 □ Divorced	Armed Forces	12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2₹☐ No If Yes, Give Yeer or Dates:		13. Was Decedent of Hispanic Origin? (Specify of Yes, specify Cuban, Mexican, Puerto Rican  1 Yes **ANo Specify:			or No- lc.)  14. Race - American Indian, Black, White, etc.  Specity: Black			
		15. Decedent's (Specify only highest)				a. Decedent's Usuat Occupation  (Give kind of work done during most of working			16b. Kind of Business/Industry			
	Elementa	ry/Secondary (0-12)	College (1-4or	College (1-4or 5+) NA		(Give kind of work done during most of work life. DO NOT use retired)  Custodian			B.W.I			
e filed within if Hygiene. other than vant, tre	17. Father's	h Grade Name (First, Middle, La						Name (First, Middle, Maiden				
DE DE M	Ed	dom D.	Greene				Etta	Etta Blount				
2 should and Mer a marke aumatic		ant's Neme/Reletionship	(Type, Print)		19b. Meiling Addre	ess (Street	and Number or F	Rural Route Numb	er, City or Town,	State, Zip Code	)	
CZNL	Ada	Terry Mi	lado		506 Loi	ng Po	oint Ch	esapeal	ce, Vir	ginia	23322	
10 - F 0	₩DBu	20a. Method of Disposition  **DOBurial 2 Cremetion 3 Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Baltimore Cemetery 08-04-99 Baltimore, MD										
pemit. Page Department of Important: If It any Injury or once.	21. Signet	re of Funeral Service Lice. Valence	in Hol	lane				altimon 1101 E				
antificate be executed ing physician and es the burial-transit	Immediate Ceuse (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):											
death cer e attendin od for use		d										
	Part II. Othe	r algnificant conditions	contributing to death I	ontributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknow			
aw requires to should 2 should pleted									an autopsy omed?	24b. Were au available completi of death	prior to on of cause	
The last he page								10	Yes 2 No	1 ☐ Yes	2 No	
certificate rector, par		se referred to medical	26. Place of Death (Check only one)									
T Gig	1 Yes		Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify)									
After Fund	27. Manner 1 ₩Net 2 ☐ Acc	ural 5 Pending investigat	ion (Month, Di	(Month, Day Year) tnjury Work?  M 1 ☐ Yes 2 ☐ No				scribe how injury occurred				
To the Hospital or Attant within 24 hours after deat To the Funeral Director: complately filled in by the Medical Certifical		4 Homicide determined building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
he Hospital in 24 hours he Funeral plately filled ledical Co		29a. Certifier (Check only and line)  29a. Certifier (Check only and line)  2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)										
Within 2		and mainer states.						License number 29d. Date signed (Month, Day, Year)				
- 3 F Ö	•	Elin &	no	0 1 35706				7/30/99				
	E	nd address of person wh	GHANJ	DVK	600	0 5	MAL	PAN 1	tosp.	BALTO	en e	
State	31. Date file	AUG 04 1	32. Regist	rar's Signatur	b. 1	na V	1					

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DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24457 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month GOSNELL 31 Juli ORMAN 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HEALTH OF 7. Aga (In yrs. last birthday) If Under 1 Year | H Under 24 Hrs. | 6. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) OVELLEA 5. Social Security Number 6. Sex Birthplaca (State or Foreign Country) 1 M 2□ F Yrs. 216-01-3768 92 APR 11, 1907 Maryland Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6116 Belair Road 21206 USA 12. Was Decedent Ever in U,S.
Angued Forces?
1 Mayes 2 □ No
If Yes, Give
Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Biack, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☒ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Greens Keeper Golf Course 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) UNK. John Gosnell 19a. Informant'a Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Gosnell/Son 3705 Elm Avenue Baltimore, MD 21211
Date 20c. Location - City or Town, Stata 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 8/2/99 Baltimore, MD.

22. Name and Address of Fecility
Cremation Society of MD, Inc. 21. Signature of Funeral Service Licen olun 1 Edward A. 299 Frederick Road Baltimore, MD 21228 Fregorchik 23a. Part1. Enter the disease, of complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death a. ACUTE MYOCARDIAL INPARCT

Due to (or es e consequence of):

CORONARY ARTERIOSCLE ROSIS Immediate Ceuse (Final disaasa or condition resulting in death) Due to (or as a consequence of): 23b. Did tobecco use contribute to the cause of death? DEMENTIA 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy findings available prior to 24a. Was an autopsy performed? completion of ceuse of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

**Physician** /Medical Examiner

ate has been signed by page 2 should be dated

cartificate

this

After Attending

ne Hospital or Attending n 24 hours after death. ne Funeral Director: Aft

To the Hosp within 24 hou To the Funer completely fil

filled in by the funeral

by

Completed

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2

Certification:

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**Physician** 

/Medicai

**Examiner** 

**Funeral** 

Director

r than "naturs!", or items 23s or 28s-f show the Medical Examiner must be notified at

permit. Pagas 1 and 2 should be filed within 72 hours aftar. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or ite any filery or other traumatic event, the Medical Example.

Baltimore, Maryland 21215-0020

Box 68760

P.O.

Records,

Division of Vital

Directo

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Completed

Be

tha Maryland

death

Examiner sician and bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Undarfying Cause (Disease or Injury that initiated events resulting in death) Last physician s the burial Physician/Medical USB as atten

Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was cesa raferred to medicei

1□ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 1 Natural 5 Pending investigation 2 Accidant

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. injury at Work? 1 | Yes 2 | No

28d. Describe how injury occurred

6 Could not be determined 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physicial: To the best of my knowledge, death occurred at the time, date end piace, and due to the cause(s) and menner as stated.

Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of

29c. Licansa number

29d. Date signed (Month, Day, Year)

no and address of person who completed cause of deeth (Item 23e) (Type, Print) HARFORD Ro. BALTO.

State Registrar

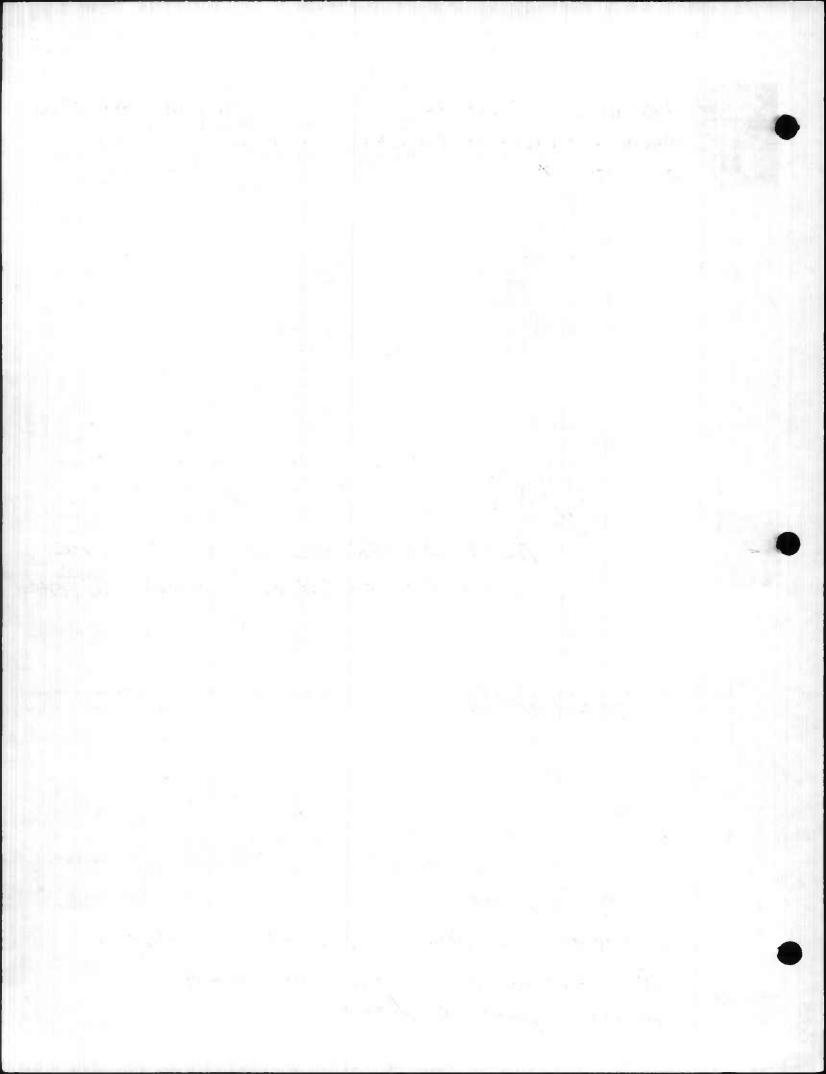
AUG 0 4 1999

31. Date filed (Month, Dey, Yeer)

3 Suicida

29a. Certifier

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 28, William F. Hoffman JULY 1999 11:10 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Villa Nursing Home Catonsville

| If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Baltimore if Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) Days Months 1 XM 2 F Yrs. 82 215-07-1171 FEB. 3, 1917 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore N/A 1 ☐ Yes 2¶ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1239 Leeds Terrace 21227 USA 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No If Yes, Give 1 ☐ Yes 2 ☐YNo Specify: white 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12 Draftsman Engineering 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William F. Hoffman Edna Miller 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred Carle Hoffman - wife 1239 Leeds Terrace, Balto., Md. 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 7/31/99 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Meadowridge Mem. Park Elkridge, Md. 21. Signature of Funeral Service Ligarian 22. Name and Address of Facility Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md., shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting In death) Nephropath Due to (or as a consequence of): Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Whiknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 28. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 1 Matural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident

Examiner burial-transit The law requires that the death certificate be executed and physician P.O. Box 68760 the attending p signed by t d be detach Records, peeu page 2 s cartificate Division of Vital

Examiner Physician/Medical by Completed To the Hospital or Attending Physician: within 24 hours aftar death.

To the Funeral Director: Aftar this cartifica completaly filled in by the funeral director, t Be Medical Certification: To

Physician

/Medical

Examiner

**Funeral** 

Director

28a-f show

ò items 23a

Director

Funeral

by

Completed

trsumstic event, the Medical Examiner trust be rightled at

the Maryland

death

Pagas 1 and 2 should be filed within 72 hours after of nent of Haalth and Mantal Hygiane. Int: If Item 27 is marked other than "natural", or Itei

permit. Pages 1 and 2. Department of Health at Important: If Item 27 is any injury or other treu

**Physiclan** 

/Medical

Baltimore, Maryland 21215-0020

Registrar

State

Ranmond Miller 31. Sate filed (Month, Day, Year)

6 Could not be

3 Sulcide

29a. Certifier (Check only one)

4 Homicide

29b. Signeture and title of certifier

AUG 04 1999

30. Neme and address of person who completed cause of death (Item 23a) (Typa, Print) 25 Man Street Smy 32. Registrar's Signature

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

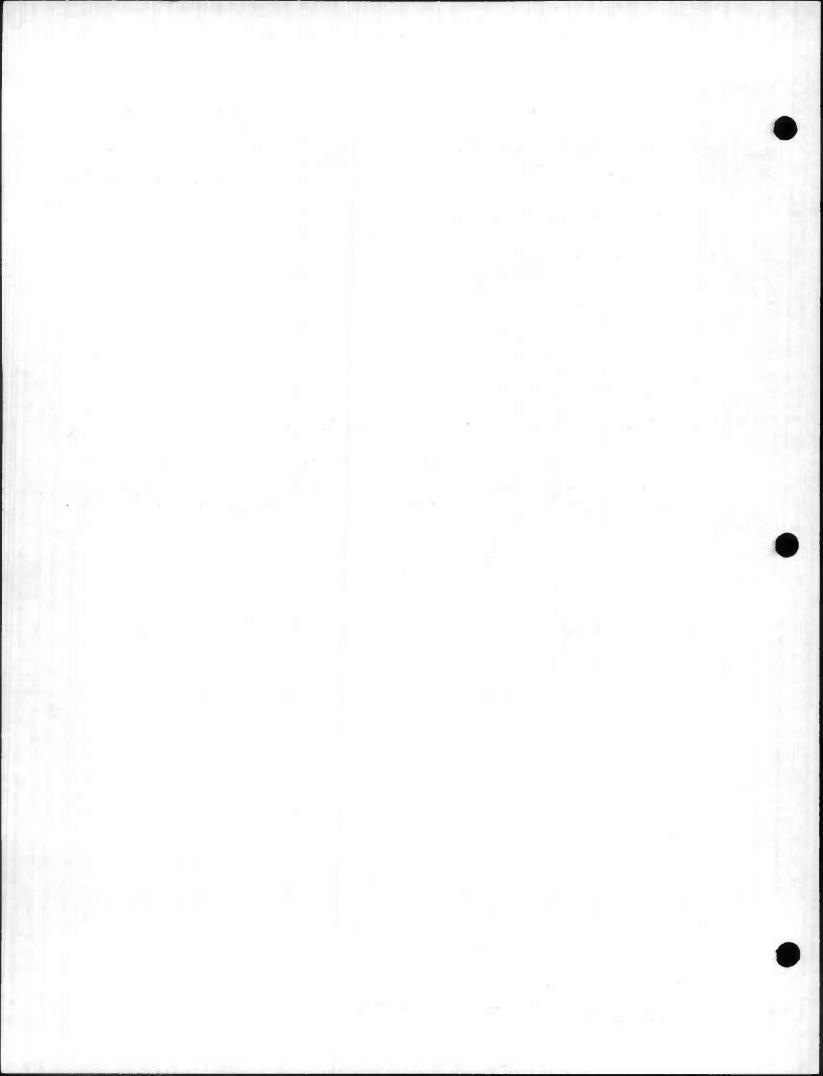
29c. License number

9/44

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Dete signed (Month, Day, Year)

MY



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month **Physician** 4:25 PM 1999 Baby boy Hnyla June /Medical 4e Facility Neme (If not institution, give street and number) 4b City Town, or Location of Deeth 4c. County of Deeth Examiner SQUARE 16. Sex Rosedale I If Under 24 Hrs. 8. Date of Birth Houra Min. (Month, Dey, Year) HOSDITAL BAITIMORE FRANKlin CenTer If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10XM 2□ F Months Deys 05 23. Director none 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23s or the Medical Examiner must be r 915 Spangler Way 21205 Funeral U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: White 1 Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Busineas/Induatry Elementary/Secondary (0-12) College (1-4or 5+) 0 None 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Pages 1 and 2 should be nert of Health and Mental is Carl Edward Hall Stephanie Hnyla 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Stephanie Hnyla/mother 915 Spangler Way, Baltimore, MD 21205 20b. Place of Disposition (Name of cometery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Facility Wade Director Ronald S. Wade State Anatomy board, 655 W. Baltimore Street Baltimore, MD 21201

23a Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final · PREMATURE BIR 18 weeks disease or condition resulting in death) Examiner Inevilable Aborlion Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-Division of Vital Records, P.O. Box 68760 The law requires that the death certilicate be Physician/Medical Due to (or as a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by the should be detached 1 Yss 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy certificate has tirector, page 2 s 1 ☐ Yes 2 ☐ No or Attending Physician: after death. Director: After this certifica 25. Wes case referred to medical examiner? Be 26. Plece of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Unpatient 2 □ ER/Outpatient 3 □ DOA Certification: To funeral 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 1 Deletural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be determined 3 ☐ Sulcide 28e. Pleca of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide To the Hospital or A within 24 hours after To the Funeral Directompletely filled in b 15 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner atated. Medical 29a. Certifier (Check only one) 29d. Date aigned (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State

Baby Boy HnylA

DR. Suresh
31. Date filed (Month, Day, Year)
AUG 0 4 1999

32. Registrar's Signature

9000 FRANKlin

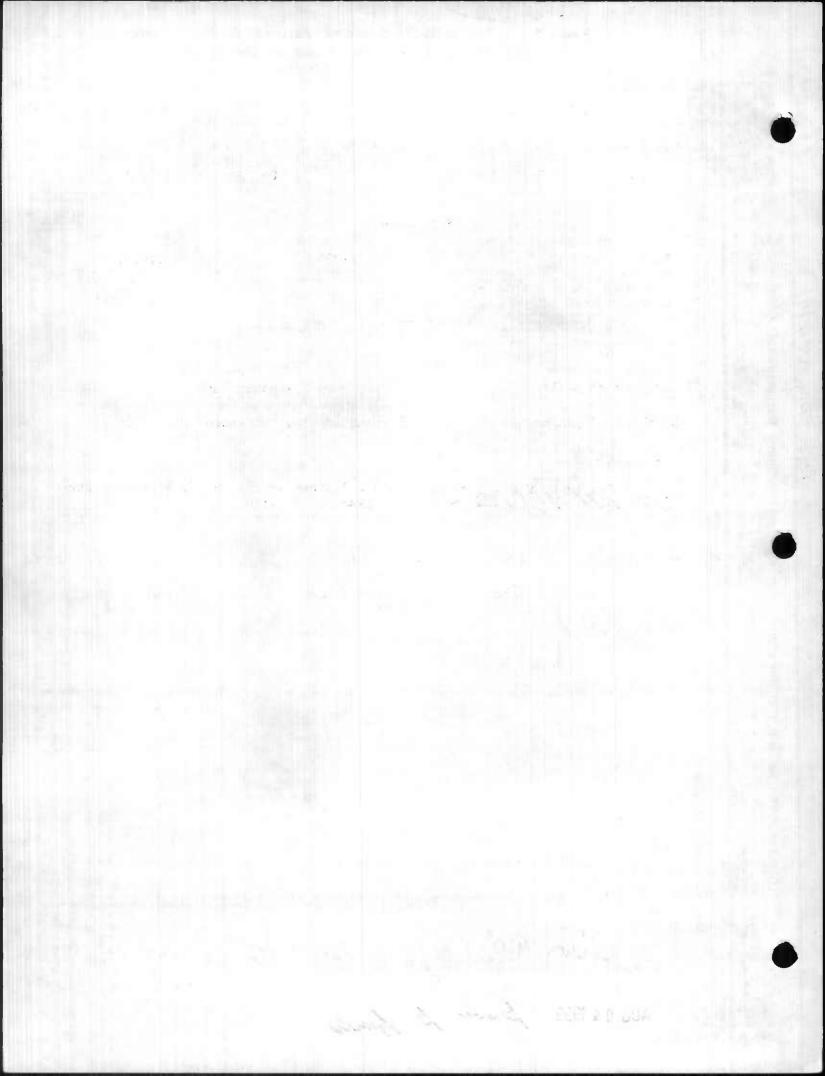
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30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

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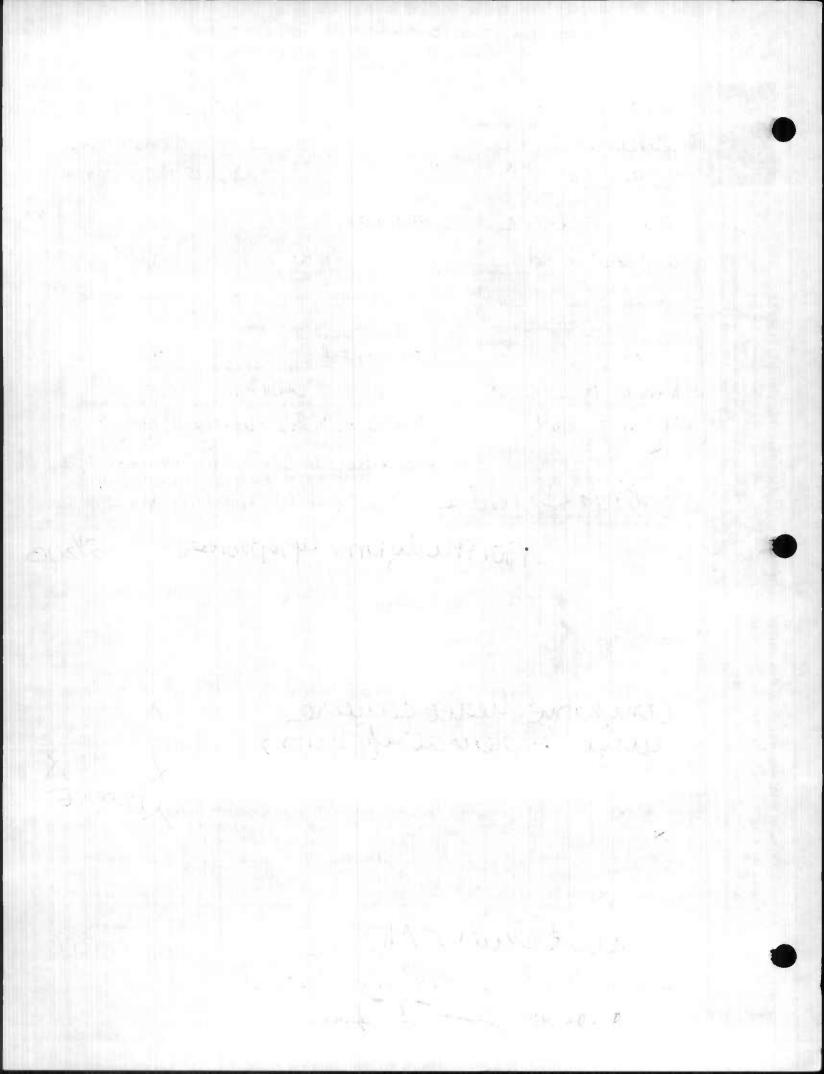
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** Holt /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Fscility Name (If not institution, give street and number) Examiner lymore 'hRi ente If Under 1 Year 9. Birthplace (State or Foreign Country)
OKLANOMA 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 XF Days Hours Min. 451-09-506. Usuel Residence of Decedent 3 Yrs Director with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other trsumstic svent, the Medical Examinar must be notified as 1 ☐ Yes 2 XNo wheeville Directo HMORE 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number 21093 Funeral permit. Pages 1 and 2 should be filed within 72 hours efter death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian Bleck, White, atc. 11. Maritel Stetus 1 ☐ Never Married 2 Merried 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 1□ Yes 200No Saltimore, Maryland 21215-0020 Specify: Specify: White 2 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) nomemaker nome 12 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be Abalym JOHNSON 10 avid 19e. Informant's Name/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of camelery, cremetory or other place) Wheeville 20c. Location - City or Town, State 20a. Method of Disposition Dete 1 Surial 2 Cremation 3 Removal from State 8 any injury once. 4 Donetion 5 □ Other (Specify) Mem IMONIUM 22. Neme end Address of Facility EVANS Funeral Chapel Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest shock, or heart fallure. List only one cause on each line. 21093 Timonium Approximete Intervel Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical **Examiner** Examiner requires that the death certificete be executed physician and the buriel-trans Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical Due to (or es a consequence of) S use a 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing 🌿 death but not resulting in the underlying ceuse given in Pert I. signed by 21 3 Probably 4 Unknown 1 Yes þ 24e. Was en eutopsy performed? 24b. Were autopsy findings aveileble prior to Completed completion of ceuse of death? certificate hes 2 1 No 25. Wes cese referred to medical examiner? Be 26. Plece of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 2 1 Inpatient 2 ER/Outpetient 3 DOA After this funeral 28e. Dete of Injury (Month, Dey Yeer) 28d. Describe how injury occurred 27. Manner of Deeth 28b. Time of 28c. Injury at Work? Certification: 5 Pending Investigetion or Attanding s efter deeth. 2 No 1 ☐ Yes 2 Accident 6 ☐ Could not be 281. Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Piece of injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours Hospital 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, and due to the cause(s) end menner es steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete end plece, and due to the cause(s) end menner steted. 29a. Certifie Medical one) To the To the To the F 29d. Date signed (Month, Day, Year) 29b. Signatyre an 30. Neme and address of person who completed ceuse of deeth (Item 23a) (Type, Print) Cantol

State Registrar 31. Dete filed (Month, Day, Year)

32. Registrer's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month JUL.Y ž0, 1999 11:25 AM Howser 4e. Fecllity Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Saint Joseph Medical Center Baltimore Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 1 M 2 □ F Deys Hours 218-28-6191 Yrs Makyland Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Detes: 11. Maritel Stetus Was Decedent of Hispenic Origin? (Specify Yee or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorcad 16e. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) DERVISOR 17. Fether'e Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Marie HOWSER 21093 Dete 3 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ⊠ Buriel 2 □ Cremetion 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Furnerel Service Licansee 22. Name end Address of Fecility Vans 23a. Pert L. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete intervel Between Onset end Deeth ACUTE RENAL FAILURE Immediate Cause (Finel 10 DAYS disease or condition resulting in deeth) Due to (or es e consequenca of): ACUTE TUBULAR NECROSIS 10 DAYS Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequenca of) Due to (or es e consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CORONARY ARTERY DISEASE 24b. Were autopsy findings evailable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? ANOXIC ENCEPHALOPATHY 1 Yes 27 No 25 No

The law requires that the death certificate be axecuted

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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Completed

Be 2

**Funeral** 

Director

r than "natural", or items 23a or 28a-f short the Wedical Examiner must be notified at

deeth with the Maryland

filed within 72 hours efter

Hygiane.

Pages 1 and 2 should be filled with timent of Haaith and Mentel Hygien tant: If item 27 is marked other the flury or other traumatic event, the

Department of Important: If any injury or

**Physician** 

Examiner

and

/Medical

21215-0020

Baltimore, Maryland

Physician/Medical Examiner the bunal-transit signed by the ed d be deteched for þ page 2 should Be Completed Certification: To

Division of Vital Records. certificate Hospital or Attending Physician: this filled in by the funeral Affer To the Hospital or Attendir within 24 hours aftar death. To the Funeral Director: A completaly filled in by the f death. edical

> State Registrar

29b. Signeture end little of cartifier

28a. Dete of Injury (Month, Dey Year)

Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29c. License number 30263

28c. Injury at Work?

1 Yes 2 No

26. Place of Deeth (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

29d. Date signed (Month, Dey, Year)

Location (Street and Number or Rural Route Number, City or Town, State)

08-01-00

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) FRANCIS KHOO, M.D.,

7601 OSLER DRIVE, TOWSON, MARYLAND 31. Dele filed (Month, Day, Year)

25. Wes case referred to medical examiner?

5 Pending Investigation

6 Could not be determined

1 Yes 2 No

27. Menner of Death

1 Neturei

2 Accident 3 Suicide

4 Homicide

29a. Certifler (Check only one)



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## Please Type or Print In Black Indelible Ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

JIM HOWE Certificate of Death Reg. No. 1. Decedent's Nema (First, Middle, Last) 2. Date of Death Dey Month Yaer **Physician** James H. JULY 31, 1999 1357 PM /Medical 4a Facility Name (If not Institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** UNIVERSITY HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Sociel Security Number 8. Dete of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) **Funeral** Months 120 M 2 F 43 213-66-7331 **Director** March 12, 1956 Maryland Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d, Inside City Limits Maryland Howard Elkridge 1 Yes 3 No Directo 288-1 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? ò 5678 Furnace Avenue 21075 U.S.A. 238 Funeral **Nems**  Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U,S. Armed Forcas? Black, Whita, atc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give 1 Nevar Married 2 Married b 21215-0020 1 Yes 2₺ No Specify: Specify: White ğ 3 ☐ Widowed 4 1 Divorced Year or Detes: Completed 16e. Decedent's Usuef Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) 12 Foreman Construction Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) ag Pages 1 and 2 should be nent of Health and Mental Frank Howe Elizabeth Coyle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) nt of Health a If Item 27 is or other tra Elizabeth A. Howe (daughter) 704 S. Baylis Street, Baltimore, Maryland 21224 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State Buriat 2 Cremetion 3 Removal from State Holly Hill Memorial Gard. 8/4/99 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Nema end Address of Facility are of Funerat Service Licens Bruzdzinski Funeral Home, P.A. in Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Approximate Approximate Interval Between Onset and Death Physician /Medical tmmediate Cause (Finel disease or condition Examiner resulting in deeth) Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Due to (or es a consequence of) Box 68760 Physician/Medicai Due to (or as a consequence of) signed by the e Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dfd tobacco use contribute to the cause of death? o 1 Yes No 3 Probably 4 Unknown ď Records, Completed by 24b. Were autopsy findings svailable prior to 24a. Wes an autopsy performed? completion of cause of death? page 2 Yes 2 No 2 No certificate of Vital Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2□ No Certification: To 1 🔲 Inpatient XER/Outpatient 3□ DOA this 28d. Describe how injury occurred

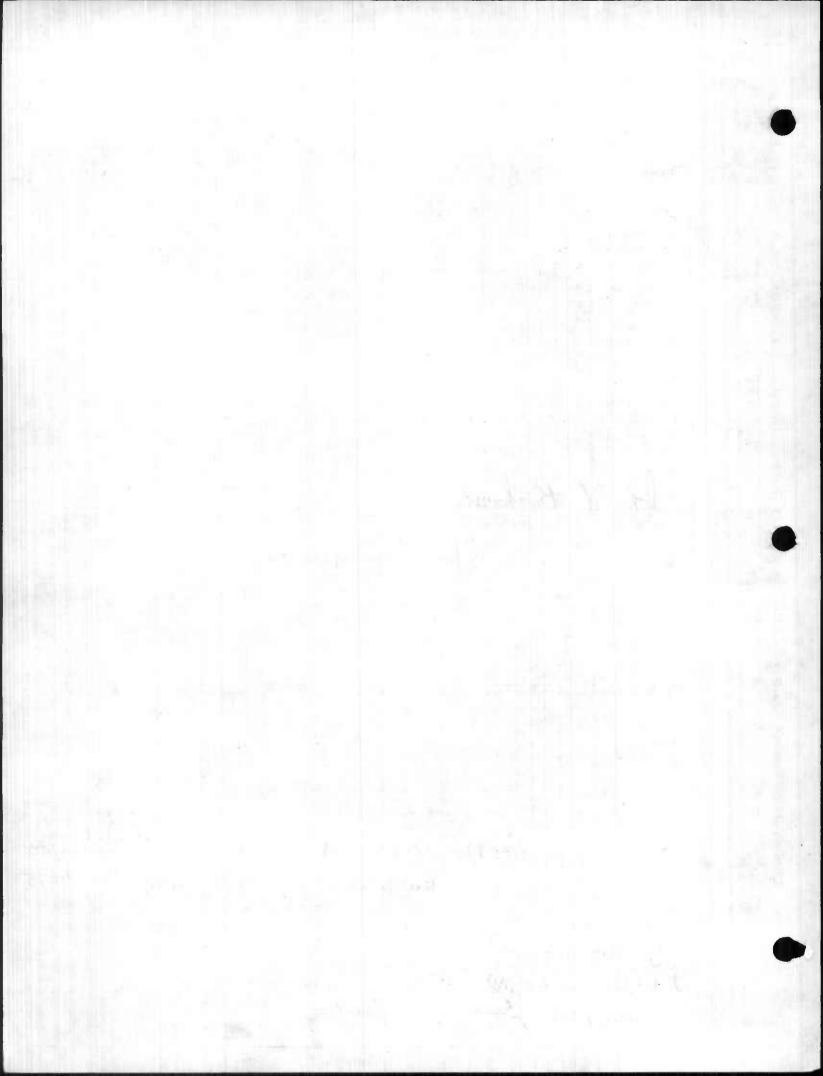
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28t. Location (Street and Number of City or Town, State)

5673 FUNCE 28c. Injury at Work? 1 X Yes 27. Menner of Deeth Date of Injury (Month, Day Year) 28b. Time of After Division 1 Netural 5 Pending Place b injury - At home, ferm, street, fectory, office building, etc. (Specify) 309 deeth. Yes 2 No ie Hospital or Attandi n 24 hours efter deeth ne Funeral Director: / investigation 25 Accident 3 Suicide dumeste 6 Could not be determined filled in by 4 Homicide DUSINESS 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the cause(s) and menner as stated.

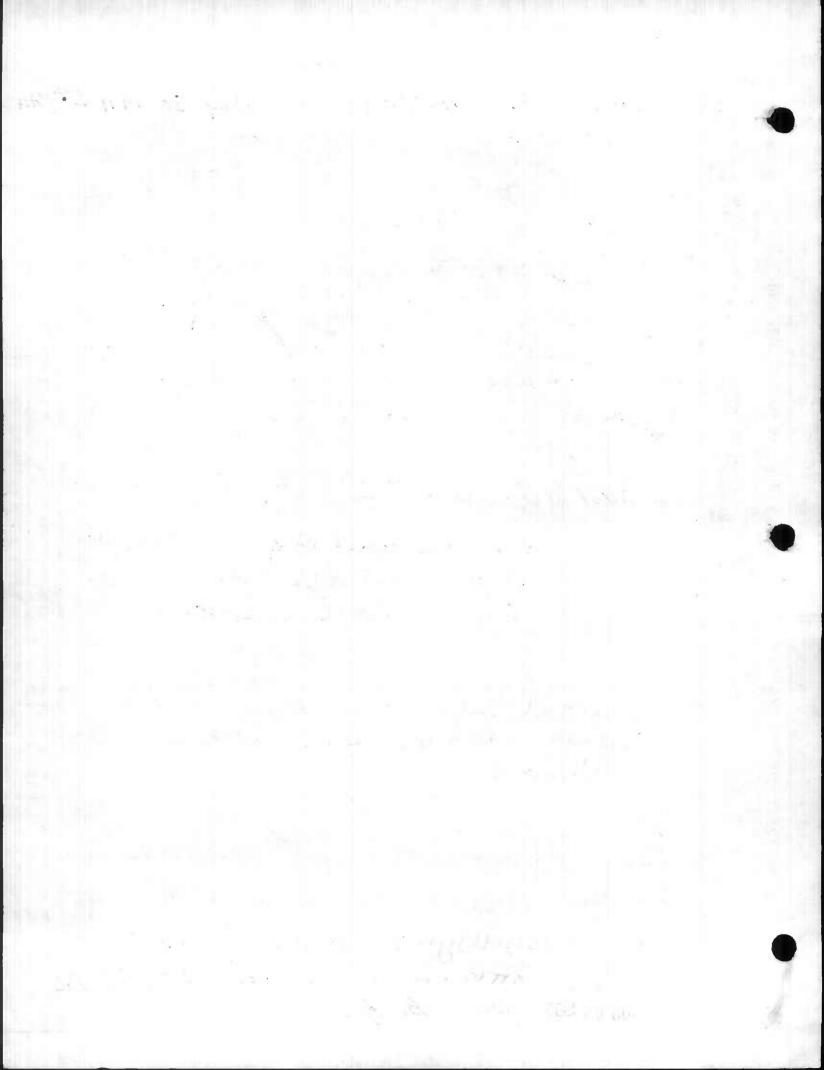
XX Medical Examiner: On the basis of axamination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated. Medical 29a. Certifie (Check only within 2 one) \$ \$ 29b. Signal 29c. License number 29d. Date signed (Month, Day, Year) 1, 1999 O.C.M.E AUG. 30. Neme and addrass of person who completed cause of deeth (Item 23e) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 37. Registrar's Signeture 31. Date filed (Month, Day, Year) State AUG 0 3 1999 Registrar



## Piease Type or Print in Black Indelibie Ink. Assure Ail Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** les 30 1999 /Medical 4b. City, Town, or Location of Beath 4a Facility Name (If not institution, give street end number) 4c. County of Death **Examiner** Liberty Medical Center Baltimore
If Under 24 Hrs. | R If Under 1 Year 8. Date of Birth (Month, Day, Year) March 28, Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1⊠M 2□ F 78 Yes 1921 215-14-5444 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1X Yes 2 No Director MD Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3212 Mondawmin Avenue 21216 U.S.A. Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ∑Yes 2 □ No If Yes, Give Year or Dates: 3 / 43 – 3 / 46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: Black 9 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hyglent Important: if item 27 is marked other that any Injury or other traumatic avant, if item 2008. School Teacher City Government unknown unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nathaniel Charles Jackson Carrie Elizabeth Curry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Jackson/spouse 3212 Mondawmin Avenue, Baltimore, MD 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burlal 2 ☐ Cremation 3 ☐ Removal Irom State 4 Donation 5 □ Other (Specify) 21. Signature of Fuperal Service Licensee 22. Name and Address of Facility Ronald Sa Wade Director State Anatomy Board, 655 w. Baltimore Street Melle 21201 Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Intervat Between Onset and Death **Physician** COMPAND robable acu /Medical Immediate Cause (Final disease or condition resulting in death) Examiner arteu Examiner tensine physician and the burial-transit that the death certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): avour. Box 68760. Physician/Medicai Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. ed by the a 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were autopsy lindings available prior to completion of cause of death? Mas an autopsy Completed 4 has > Dreage 2 1 No 1 Yes 1 Tyes 2 No certificate edical Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3E DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 D Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t Hospital or Attanding 5 Pending Investigation t hours after death.

'uneral Director: After only filled in by the fur 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide in 24 hour. the Funeral Directory 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hos To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and addrass of person who completed cause of death (Itel mpleted cause of death (Item 23a) (Type, Print) 2300 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 0 4 1999 Registrar



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Data of Death 3. Time of Death 1. Decedent's Neme (First, Middla, Last) Yaar Month Day 2, AUGUST 1999 JOHNNIE MAE JONES 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death 3720 ECHODALE ROAD BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foraign Country) Yrs. 1.28-26-861.3 65 ANDERSON, SC Usual Rasidence of Decedent 10b. County 10c. City, Town or Location 10d. Insida City Limits MD N/A BALTIMORE 1 XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3720 ECHODALE ROAD 21.206 U.S.A. 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 ☐ Yas 2 ☒ No If Yas, Giva Year or Dates: 1 Never Married 2 Married BLACK 1 Yas 2 No Specify: Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupetion (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SEAMTRESS 12 SELF EMPLOYED 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) UNKNOWN GRACIE SLOAN 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) SHERITA & KEITH PENLAND 3720 ECHODALE RD, BALTIMORE, MD 21206 20b. Place of Disposition (Nama of cemetery, cramatory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1X Burial 2 ☐ Cremation 3 ☐ Removel from State DRUID RIDGE CEMETERY 8-7-99 OWINGSMILLS, MD 4 ☐ Donation 5 ☐ Othar (Specify) o Funeral Service Licenses 22. Nama and Addrass of Facility HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTO. MD 21207 or complications that caused the de List only one cause on each ine. Approximate Interval Batween Onset and Daath th. Do not antar tha moda of dying, such as cardiac or respiratory arrest, Colon Carier Metastatic Immediata Causa (Final disaase or condition resulting in daeth) Dua to (or as a consequence of) Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last Dua to (or as a consequance of): Dua to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 □ Yes 2 1 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to 24a. Was an autopsy completion of cause of death? 1□ Yas 3 No 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medical 26. Piace of Death (Check only ona) Other: 4 Nursing Homa Masidance 6 Othar (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yas 2 No 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 27. Mannes of Death 28b. Tima of 28d. Describe how Injury occurred 1 ☑Natural 2 ☐ Accident 5 Pending 1 Yes 2 No

The law requires that the death certificate be executed Box 68760, 88 P.O. I signed by Records. page 2 should certificate of Vital or Attending Physician: director this funeral After Division death. after death filled in by 24 hours a

Physician/Medicai þ Certification: To

Completed Be

**Physician** 

/Medical

Examiner

10a, Stata

**Funeral** 

Director

ns 23a or 28a-f show must be notified at

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altimore, Maryland 21215-0020

Pages 1 and 2 should be nent of Health and Mental

Department of Health a Important: If Item 27 is any injury or other tra-

**Physician** 

/Medical

Examiner

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Director

Funeral

Completed

Be

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Examiner

29a. Certifier

3 Suicida

4 Homicide

(Check only one)

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

6 Could not be determined

invastigation

29b. Signetura endyitta of certifie

29c. License number

28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

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29d. Data signed (Month, Day, Year)

281. Location (Street and Number or Rurel Route Number, City or Town, State)

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State Registrar

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Medical

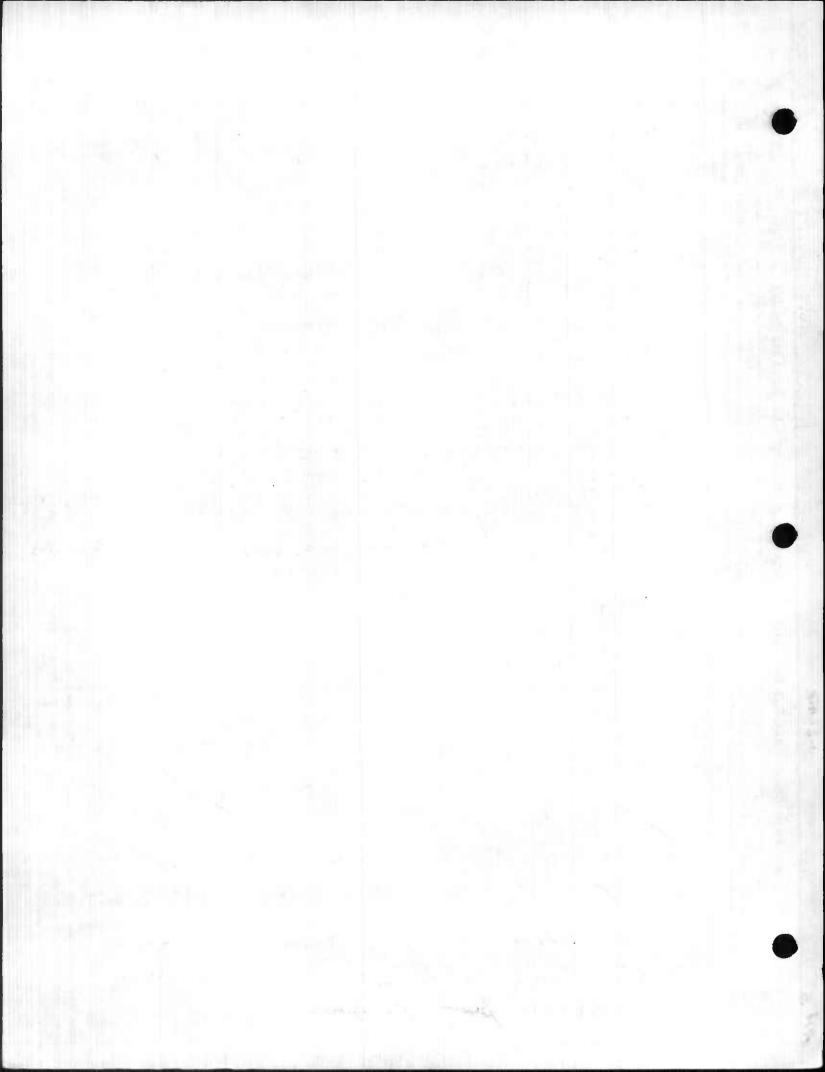
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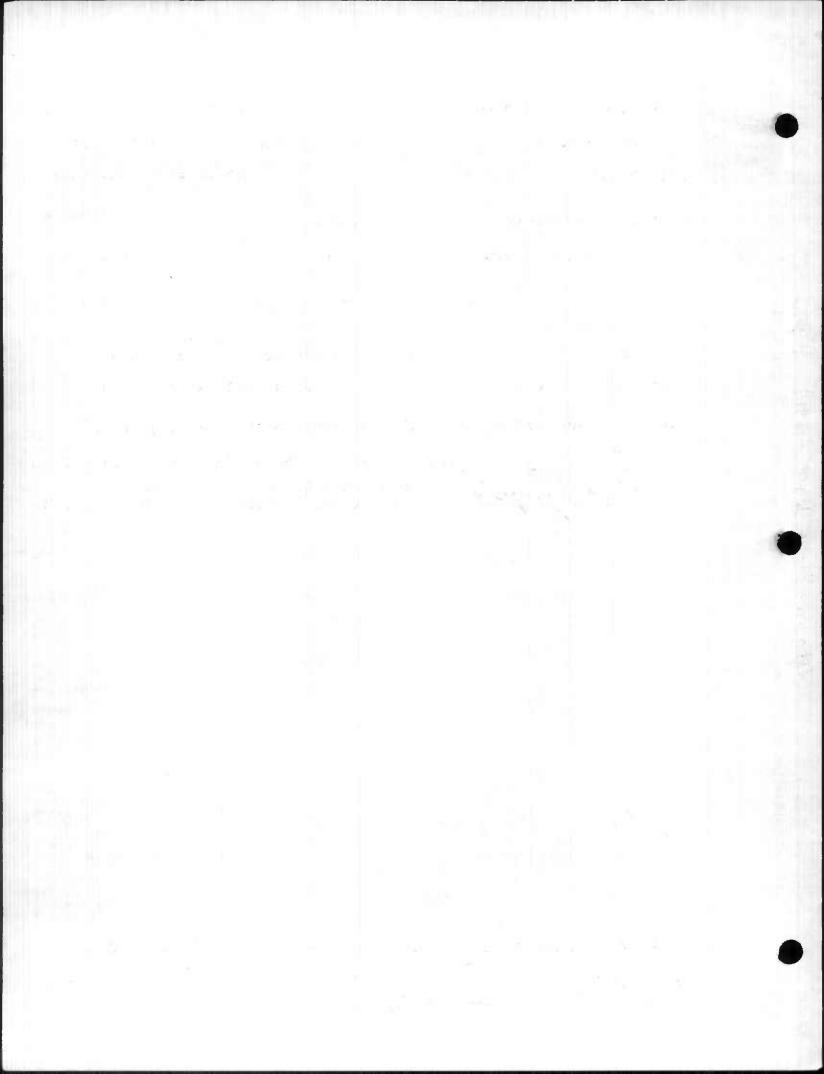
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Hospital



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		Certificate of De	eath	F	Reg. No.	24465					
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altimore mit. Pages 1 cperiment of He portant: if item y injury or others.		1 Burial 2 XCramation 3 Removel from Stata 4 Donetion 5 Other (Specify)  Metro Crematory	т - 0	12.100	D 1. 1						
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** Month Day ASPER 1999 ) ALISR <AYMODD :50 P.M 10LY 86 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GERERAL FAUSION If Under 24 Hrs. (ATT920) HARFORL MORTHAL If Undar 1 Yaar 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Yeer) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. ØM 2□ F Yrs JULY 24, 1930 Director 313 79 1208 MARY Usual Residence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show traumatic avent, the Medical Examiner must be notified at 1 ☐ Yes 2 No 28a-f s Directo HARFORL MARYAM ABinboor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Herns 23a permit. Pages 1 end 2 should be filed within 72 hours after death v. Department of Health end Mantal Hygiene. important: If item 27 is marked other than "natural", or items 28a any injury or other traumatic avent, the Medical Examiner mans once. 1413 181V3 U.S.A Funeral 21009 14. Race - Americen Indian, Black, White, atc. Was Decedent Ever in U.S. Armed Forces? 13. Was Dacedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Yas 2 No If Yes, Give Year or Dates: KcRA 1 Naver Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 No Specify. Ď 3 ☐ Widowed 4 ☐ Divorced THW Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Eiementary/Secondary (0-12) Coilege (1-4or 5+) OSPEC 127 RS GENERAL MOTORS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Sumama) Be 2 word JASPER A 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19e. Informant's Name/Relationship (Type, Print) AG 100 DO MARYLAND Date 20c. Location - City or Town, State 1413MYLAONS DRIVE 1. JASPIC 1 LARGARST Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date AU6.2 Buriel 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) AR BALTIMORE, MARYLAND 1999 rondal 22. Nama and Address of Facility HAPIL 21. Signalure of Funeral Service Cicenses -BZLAIR, P.A. FORUST HILL MARYLAND 3 NEWPORT URIVE 23a. Pert1. Enter the disease, or complications that caused the daath. Do not enter tha moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final Von Smillell Lung Lancer 101. puths disaasa or condition rasulting in death) Examiner Due to (or as a consequence of): Examiner Radiation Theursoni 2 Months or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Difficille Box 68760, lostridium Physician/Medical Due to (or as a consequenca of): Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? been signed by t Yes 2 No 3 Probably 4 Unknown by Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of causa of daath? ate has page 2: 2 No cartificate 1 Yes 1 Yas 2 No Be 25. Was cese referred to medical examiner? 28. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Affer Netural 5 Pending investigation after death. 1 Tyes 2 No 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide within 24 hours a To the Funeral C Hospital TS Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the ceuse(s) end menner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, dete end place, and due to the cause(s) and manner stated. 29a. Certifier Medical the

State Registrar

31. Dete filed (Month

29b. Signature and title of certiler

30. Neme and address

irasqilan; UG 0 4 32. Registrar's Signature

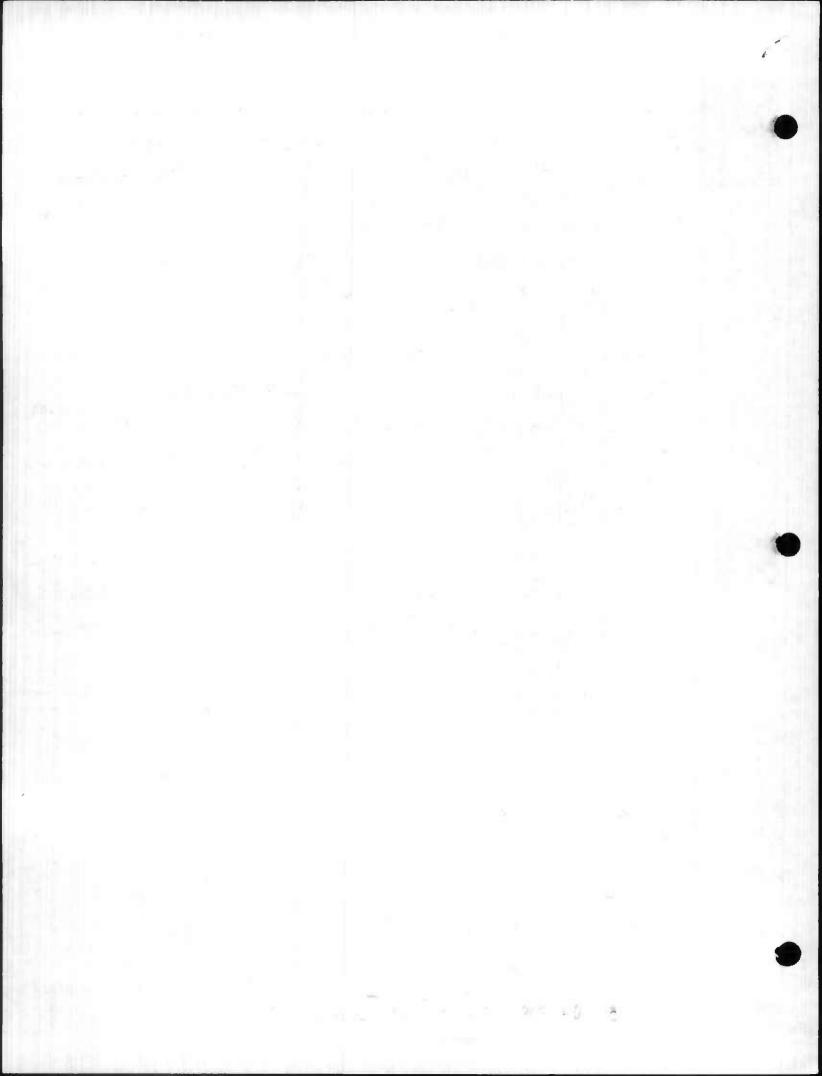
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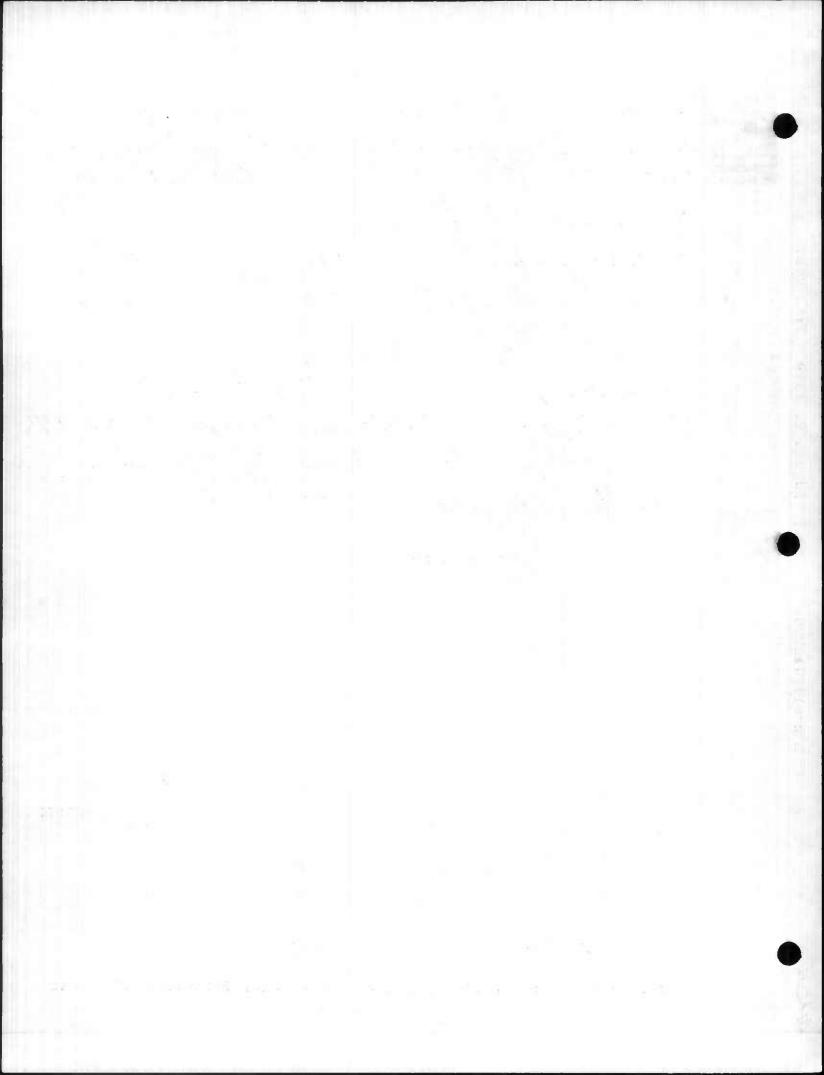
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29c. Licanse number

29d. Date signed (Month, Day, Year)





#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death .Day 1999 July 31, Mildred Jenkins 2:59 PM 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death 2315 Edwards Lane Bel Air Harford if Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Months Days Hours Min. March 6, 1923 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1□ M 21 F 216 18 6756 76 Yrs. Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 162 Orville Road 21221 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritai Status 1 □ Never Married 2 □ Married 1 ☐ Yas 2 🖾 No Specify: Specify: White 3X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk Steel Mill 17. Fathar's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Michael Hartnett Ethel Sternsdorff 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ted M. Jenkins (son) 2315 Edwards Lane Bel Air, Maryland 21015 20a. Method of Disposition T☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 8/3/1999 Baltimore, Maryland uture of Function 22. Name and Address of Fecility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland 21221 Inter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, or heart failure. List only ona cause on each line. Approximete Intervel Between Onset end Death Immadiata Cause (Final 4 Months . Non Small Concer disease or condition resulting in death) Dua to (or as a consequence of): Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Causa (Disease or Injury that initiated avents resulting in death) Lest Dua to (or as a consequence of): Due to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3⊠ Probably 4 Unknown 24b. Were autopsy findings aveileble prior to completion of cause of death? 24a. Was en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case rafarrad to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Rasidance 6 Nother (Specify) Residence

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

items 23e

should be filed within 72 hours after of Mental Hygiene.

marked other than "netural", or itel

Baltimore, Maryland 21215-0020

Examiner must be notified at

traumatic event, tre Medical

Director

Funeral

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Completed

physician and s the buriel-transit been signed by t should be detech page 2

The law requires that the death certificate be executed Box 68760 P.O. Records, Division of Vital To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Examiner Physician/Medical þ Completed Be Medical Certification: To

State Registrar 29b. Signature and title of certifier

AUG 0 3 1999

31. Date filed (Month, Day, Year)

5 Panding invastigation

6 Could not be

1 ☐ Yes 2 XNo

27. Mannar of Death

2 Accidant 3 Suicide

4 Homicida

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and mannar stated.

28a. Data of Injury (Month, Day Year)

1 Inpatiant 2 ER/Outpetient 3 DOA

28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify)

28b. Tima of

29c. License number

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

Cartifying Physician: To the best of my knowladga, death occurred at the time, data and place, and due to the causa(s) and mannar as stated.

2 Madical Examiner: On the basts of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the causa(s)

29d. Date signed (Month, Day, Year)

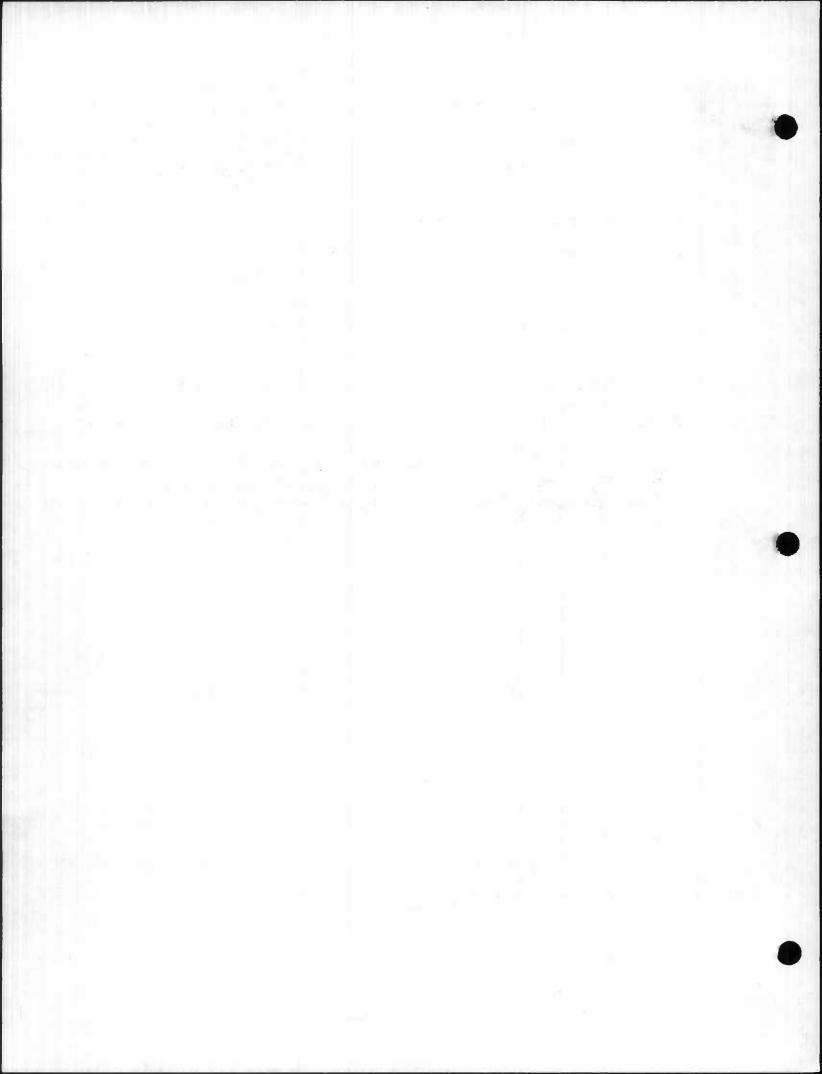
28f. Location (Street and Number or Rurel Route Number, City or Town, State)

28d. Describe how injury occurred

Lutherville MD

30. Name and addrass of person who completed cause of death (Itam 23a) (Type, Print)

COOPER SANG



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Death Day 1999 Month August 3, **GEORGE** KARAGEORGOS 5:55 AM 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore | Hundar 1 Yaar | Hundar 24 Hrs. | 8. Data of Birth (Month, Day, Year) | Oct. 15, 1930 5. Social Sacurity Number 7. Age (In yrs. last birthday) Birthpiace (Stata or Foreign Country) 1**∑** M 2□ F Yrs. 160-52-2433 68 Greece Usual Rasidanca of Dacedant 10a Stata 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 Ñ No Baltimore Md. Lutherville 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 1623 York Rd. 21093 USA 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Nevar Married 2 Married 1 ☐ Yas 2 ☑ No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highast grada completed) Elamantary/Secondary (0-12) College (1-4or 5+) Photographer Valley Studios 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Surnama) Vasiliki Panagiotis Karageorgos Karageorgos 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 1623 York Rd. Lutherville, Md. 21093 Mr. Panagiotis Karageorgos/son 20a. Mathod of Disposition 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20c. Location - City or Town, Sfata 1X Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) 8/6/99 York, Pa. Mt. Rose Cemetery 22. Nama and Addrass of Facility Ruck Towson Funeral Home, Inc. 23a. Part1. Entar tha diseasa, or complications that caused tha daath. Do not enter tha moda of dylng, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona ceuse on each line. Approximata. nterval Batween Onsat and Death Immedieta Causa (Finel Lung Cancer diseasa or condition rasulting in deeth) Due to (or as a consequanca of): Sequantially list conditions, if any, laading to immadiata cause. Entar Undarlying Causa (Disease or injury that initieted avants resulting in daath) Last Due to (or as a consequence of): Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nunknown 24b. Wara autopsy findings available prior fo 24a. Was en eutopsy complation of cause of death? 1 ☐ Yas 2X No 1 ☐ Yas 2 ☐ No 25. Was casa rafarrad to medical 26. Placa of Death (Check only ona) Other:  $_{4}\square$  Nursing Home  $_{5}\square$  Residence  $_{6}$  Nother (Specify)  $_{HOSPICE}$ Hospital: 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how injury occurred 28b. Tima of 1 Natural
2 Accident 5 Panding 1 ☐ Yes 2 ☐ No invastigation 6 Could not be datarmined 3 Suicida 28a. Place of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida

P.O. Box 68760, Karageorgos Records, George Vital ot Division

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**Physician** 

/Medical

**Examiner** 

Director

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**Funeral** 

Director

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permit. Peges 1 and 2 to Department of Haalth ar Important: If Item 27 Is any Injury or other trau

**Physician** /Medical

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Physician/Medicai

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State Registrar 29b. Signatura and title of certifiar

29c. Licensa number D43725

1 Ccritifying Physician: To the best of my knowledge, daath occurred et tha tima, data and place, and due to the ceuse(s) and mennar as stated. 2 Medical Examiner: On the basis of exeminetion and/or invastigetion, in my opinion, death occurred at the time, data and pleca, and due to the cause(s) and manner stated.

29d. Data signed (Month, Day, Year)

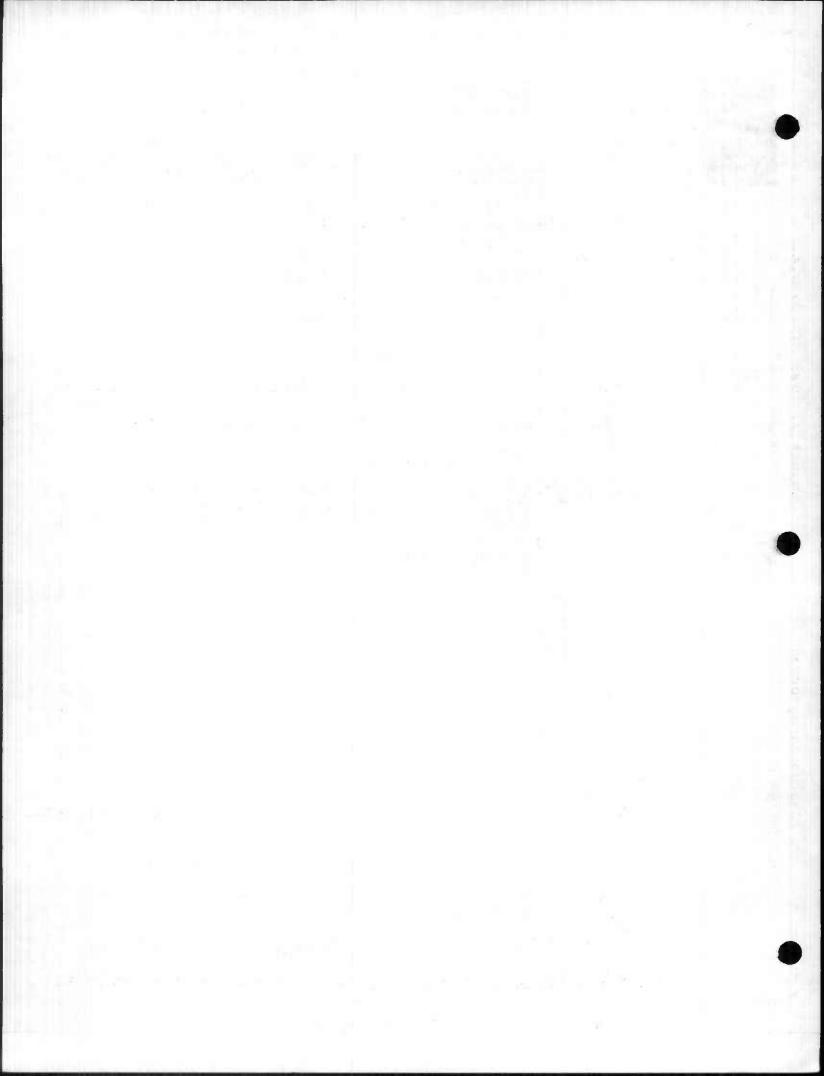
30. Nama and addrass of person who completed causa of daath (Item 23e) (Type, Print)

Dr. Tariq Mahmood, 2300 Dulaney Valley Road, Timonium, MD 21093

31. Date filed (Month, Day, Year) 22. Ragistrar's Signatura



**DHMH 16 Ray 6/95** 



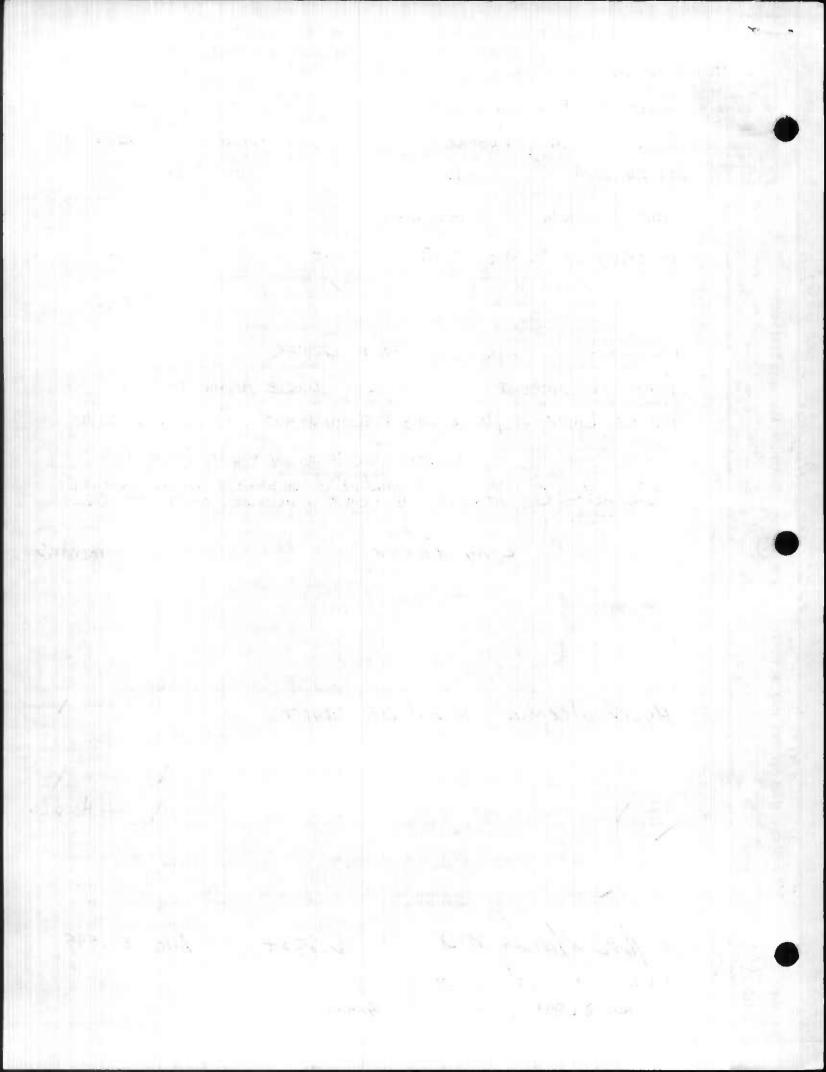
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 AMEND ITEM: #30 PER V.R. G774 8-4-99 WR. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Dey **Physician** -02-99 12:40 PM JAMES K. LAMBERT 08 · /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street end number) Examiner KITCHIE JOSEPH HOSPICE BALTIMORE NIA If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 03 · 20 · 23 If Under 1 Year Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (fn yrs. lest birthdey) 6. Sex **Funeral** Deys Months 10 M 20 F 217.26. 2024 16 Director Usual Residence of Decedent the Marylend 10b. County 10c. City, Town or Location 10e. State 10d. inside City Limits 7 is marked other than "natural", or Nema 23a or 28a-f show treumatic event, the Medical Examiner must be notified at 1 Yes 2 No NIA BALTIMORE Director MO 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 21218 USA 918 GIUN VENUE Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Meritel Status 2 Married Yes 2 No 1 ☐ Never Merried 1 ☐ Yes 2 ☑ No Specify: Baltimore, Maryland 21215-0020 Specify: BLACK þ 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Buaineas/Induatry Pages 1 end 2 should be filed within nent of Health and Mental Hygiene. Int: If Nem 27 Is marked other than " Elementery/Secondary (0-12) College (1-4or 5+) IRUCK DEIVER 9 TH GRADE NA 17. Fether'a Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be WILLE K. LAMBERT ANNA JAMES MASON 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTO. MD. 21218 BERNICE BELGIUN LAMBERT permit. Pages 1 end Department of Health Important: if Item 27 any Injury or other tr 20b. Plece of Disposition (Neme of 20e. Method of Disposition Dete 20c. Location - City or Town, State cemetery, cremetory or other piece) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from Stete PARK CEMESERY BALTO. MO 8.6.99 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility C. GREENE FUNERAL SERVICE VAUGHN 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. BALTO. MD. 21229 **Physician** months /Medical Immediate Cause (Fine) diseese or condition resulting in deeth) Examiner Examiner physicien and s the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of): attending pl ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown signed by LAMBERT Renal cell Hyper calcemia P Q 24b. Were autopsy findings evelleble prior to completion of cause of death? 24e. Wes en autopsy performed? Completed has 1 Yes certificate funeral director, 25. Wes case referred to medical exeminer?

1 Yes 2 No 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Deet 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. tnjury et Work? Neturel 5 Pending or Attendination after death. Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of injury - At home, farm, atreet, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide To the Hospital within 24 hours a To the Funeral D completaly filled in 29a, Certifier Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and plece, end due to the ceuse(s) and menner es stated. Medical (Check only one) 2 Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, dete and piece, end due to the cause(a) and menner steled. 29c. License number 29d. Date signed (Month, Dev. Year) 29b. Signature agel title of 30. Name and eddress of person who completed ause of deeth (Item 23e) (Type, Print)

State Registrar 31. Date filed (Month, Dey, Year) AUG 04 1999

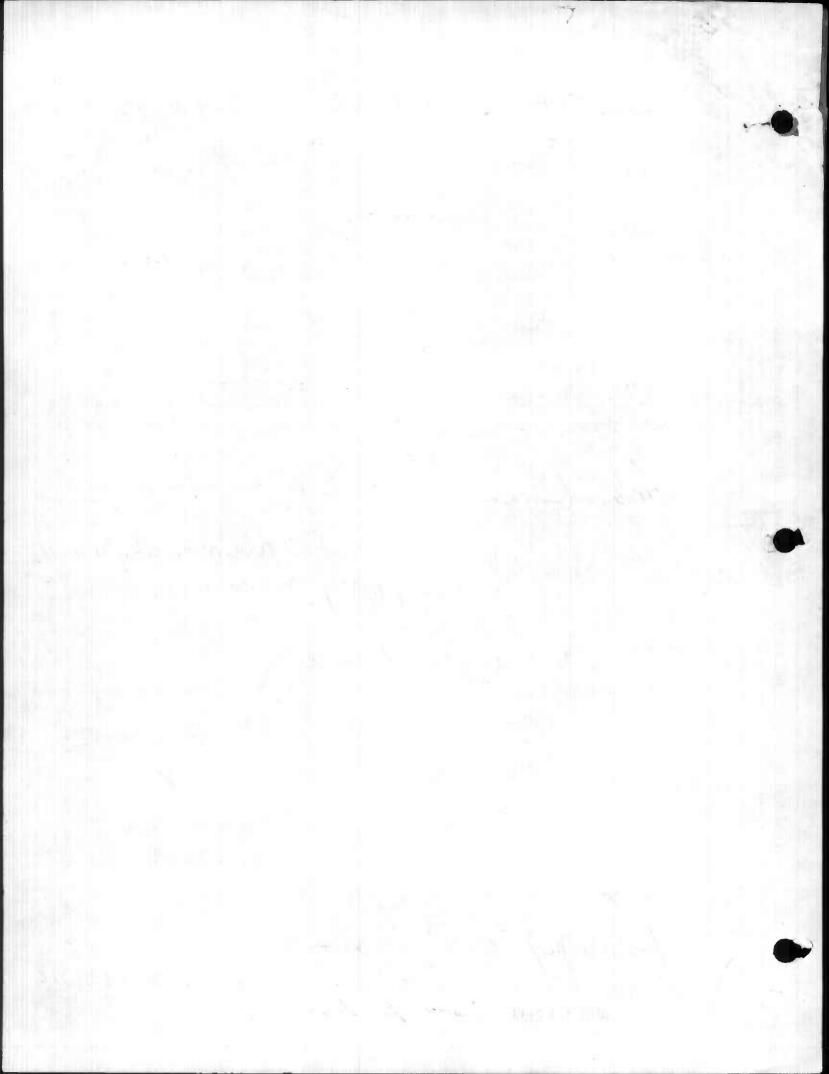
PAUL E. GORMLEY 900 CATON AVE. BALTIMORE, MD 32. Registrer's Signeture

21229



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	State of Maryland / Department of Health and M  Certificate of Death	ental Hygiene  Reg. No. 9 9 2 [; ], 7 ]
Physician /Medica	NCCKE I LU TILL DEL MEY	2. Date of Death Month Day Year 10:39A
Funeral Director	4a Facility Name (If not institution, give street and number)  Johns Hopkins [Hospital  5. Social Security Number  1 M 2 F 71 Yrs.  4b. City, Town, or Lot B 1 timore B 1 timore Win.  4b. City, Town, or Lot B 1 timore B 12 Timore Towns All Under 1 Year   H Under 24 Hrs. Months Days Hours Min.	10000000
Maryland -f ahow fied at	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
or 28s	Md. N/A Baltimore City  10e. Streel and Number 10f. Zip Code	Yes 2 □ No 10g. Citizen of What Country?
5 E S		U.S.A. cify Yes or No- Rican, etc.)  14. Race - American Indian, Bleck, White, etc.  Specify: Black
within 72 one. The Wedler	15. Decedent's Education (Specify only highest grade completed)  Elementery/Secondary (0-12)  12th  15. Decedent's Usual Occupation (Give kind of work done during most of working the completed)  Idea. Decedent's Usual Occupation (Give kind of work done during most of working the complete of the comple	16b. Kind of Business/Industry  Hospital
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Nore, Mary ges 1 and 2 sho nt of Health and 1 if item 27 is me or other traum	19a. Informant's Name/Reletionship (Type, Print)  19b. Mailing Address (Street and Number or Rura  LaContis Howard/Daughter  105 E. 43rd Street, A  20a. Method of Disposition  1 Burlal 2 Premation 3 Removal from State	Date   20c. Location - City or Town, State, Zip Code)  Date   20c. Location - City or Town, State  (3/99   Catonsville, Md.
Baitin Permit. Pa Departmen Important any Injury	21. Signature of Fugural Service Lightness 22. Name and Address of Facility William C. Brown Co.	mmunity Funeral Home
Continued of the conficuence of	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as e consequence of):	Interval Between
P.O. date the detached by the	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco uss contributs to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown
COT requirements		24a. Was an autopsy performed?  24b. Wera autopsy findings available prior to completion of cause of death?
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Oivision or Attending effer death. Director: After in by the fune striff cation		28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)
To the Hospital within 24 hours to the Funeral completely filled		and due to the cause(s) and menner as stated.  and at the time, dete end piece, and due to tha cause(s)
Comit To #	29b. Signature and title of certifier  29c. License number  29c. License number  29c. License number  29c. 4476	29d. Dete signed (Month, Day, Year)  7 30 99
IKY	24 Date Blad (Month Day Veer) 00 Destate de Classition	d Balto MD 21216
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physician Box 68760 P.O. Records, Division of Vital | I or Attending Physician: efter death. Director: After this certific within 24 hours e To the Funeral D

**Physician** 

Examiner

Director

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**Funeral** 

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tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at

Peges 1 and 2 should be filed within inent of Health end Mental Hygiene. Int: If Item 27 Is marked other than "I Iry or other traumatic event, Iha Max

permit. Pege Depertment o Important: If i any Injury or

**Physician** 

/Medical Examiner

Examiner

Physician/Medical

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Completed

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Certification:

(Check only

29b. Signature and title of certifier

the Maryland

3altimore, Maryland 21215-0020

/Medical

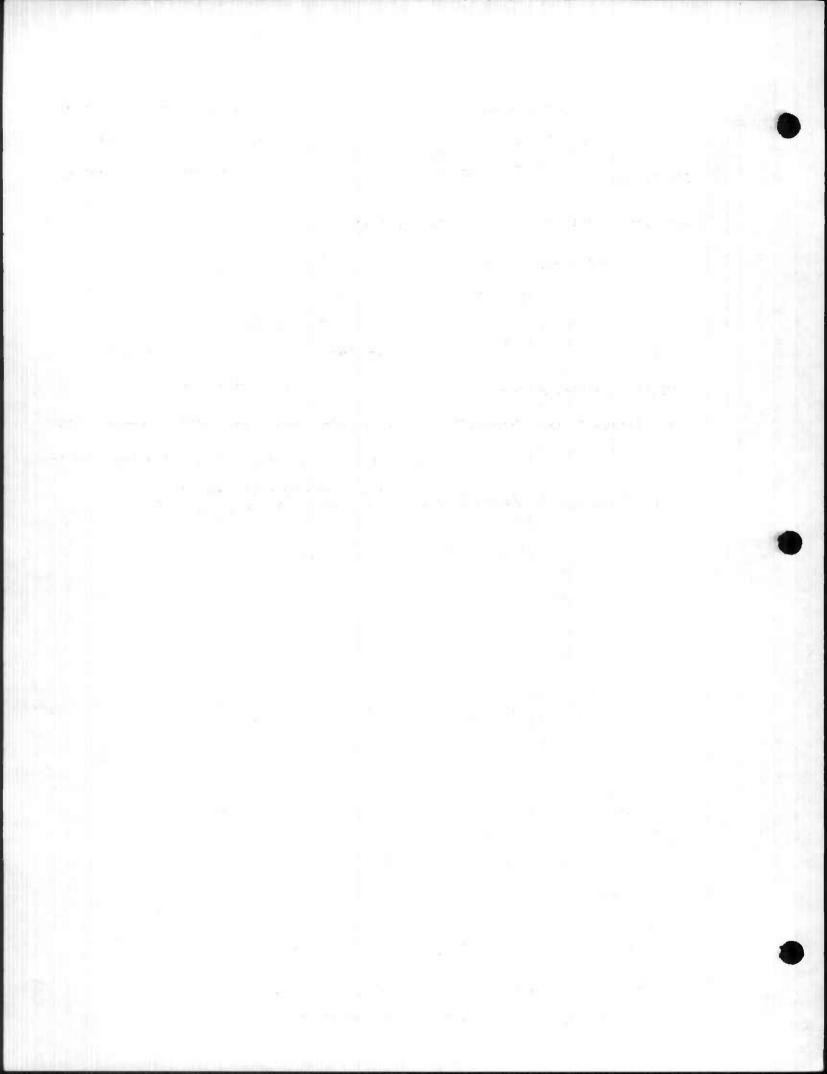
State Registrar

AUG 0.4 1999

32. Registrer's Signature

29d. Date signed (Month, Dev. Year)

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 6701 N. CHARLES, BALTOMO 21204 MITCHELL 1NSK1



B.K.S UNKNOW		Please	Type or Print in Blac State of Maryland /		Health and N	lental Hygi	ene 99	24473	
	sician	1. Decedent's Name (First, Middle, La	don McFai	1	Deam	2. Data of Death Month	Day Yea 31, 1999	3. Time of Death	
	edical miner	4a Facility Name (ff not institution, glv		4b. City, Town, or L BALTIMO	ocation of Death	4c. County of De			
Fune Direct		5. Social Security Number 6. S 218-15-16-56		irthday) If Under 1 Yaar Wonths Days	The second secon	8. Date of Birth Month, Dey Jan 17	Year) 9. E	Birthplace (State or Foreign County) Mary land	
Maryland of show	P	Usual Residence of Decedent  10a. State 10b. County  Many and 1	A 10c. City, Tow	11.11:	Dre			10d. Inside Offy Limits 1 ☑ es 2 ☐ No	
death with the Maryland ma 23a or 28a-f show	Funeral Director	100. Street and Number 2406 Montices	lo Rd.	10f. Zip Code	21216	10	og. Citizen of What	Country?	
0020 ours after death with the Maryla ral', or Home 23e or 28e-f shor	by Funer	11. Marital Status  1 Navar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ Yoo If Yes, Giva Year or Dates:	13. Was Decedent of I If Yes, specify Cub	oan, Mexican, Puerto	penic Origin? (Specify Yas or No- Mexican, Puerto Rican, etc.)  14. Race - Amaric Black, White.  Specify:  Specify:  Specify:			
15-C	letec	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		Decedent's Usual Occup (Give kind of work done lifa. DO NOT use retire	during most of worked)	ing	6b. Kind of Busines  Cando	er Yards	
日 多重なる	To Be C	17. Father's Name (First, Middle, Last)	tail		<del>i</del>	e (First, Middle, M Hia R	leiden Sumame)		
Hoall an		19a. Informant's Name/Fleiationship (	ctail-mother	b. Meiling Address (Street ZHOL Mon of Disposition (Neme of	tiend Number or Rui Ficello	Rd. Ba	City or Town, State  MONL  Oc. Location - City	Maryland	
Page Page nent o ant: If I		1	Removal from State  ### Command	22. Name and Address	retery!	8/5 6	andsdov	ne Maylan	
Balti permit.   Departm importar	Suce	> Kevin	Parker	3572 Fre	derick	Ave. Bo	utimore !	MD. 21229	
Physicia /Medic Examin	al er	23a. Part1. Entar the disaase, or com shock, or heart failure. List only Immediate Cause (Final diseasa or condition resulting in death)	a Multipl	e Stab			St,	Approximate Interval Between Onset and Death	
axecuted in and ial-transit	Examiner	Sequentially list conditions, if any, teading to immediate	b. Due to (or as a						
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. 0 00	y Physician/Medical	Part II. Other significant conditions of	ontributing to death but not resulting	iven in Part t.	23b. Did tobacco use contribute to the cause of dea				
Records, P.O. a law requires that the has been signed by the ge 2 should be detached.	Completed by					24a. Was an perform		b. Wera autopsy findings available prior to completion of cause of death?	
_ F # 8	e Com	25. Wes case referred to medical			26 Place of Dee	th (Check only one	8 2□No	1. Yes 2□ No	
Of Vital Physician: T this certifical ral director, p		axaminar? D∑Yes 2□ No	1	utpatient 3L DOA	her: 4 Nursing Ho	oma 5 🗆 Resida	nce 6 XXX ther (S	pecify) AT SCENE	
IVISION  * Attending  her death.  Inector: After  n by the fune	ertification:	27. Manner of Death  1 Natural 5 Pending investigetion  3 Suicide 6 Could not be determined	(Month, Day Year) Found 199 Un 7-31-99 Un 28e. Place of Injury - At home, fi building, etc. (Specify)	arm, street, factory, office	Yes 2 No		eet and Number or Stele) 3 5 00	tabbed Rurel Route Number, Block Gwynn Fai	
o the Hospital of thin 24 hours at the Funeral Dimpletely filled in	Medical C		yelclan: To the best of my knowledge iner: On the basis of examinetion are and manner stated.	e, deeth occurred at the ti	ime, date and place, opinion, deeth occur	red at the time, da	use(s) end menner	due to the cause(s)	

Division of Vital Records. To the Hospital or Attending Physician; The law requires page 2 should be within 24 hours after death.

To the Funeral Director: After this certificata has completely filled in by the funeral director, page 2

29b. Signatura and titla of certifian

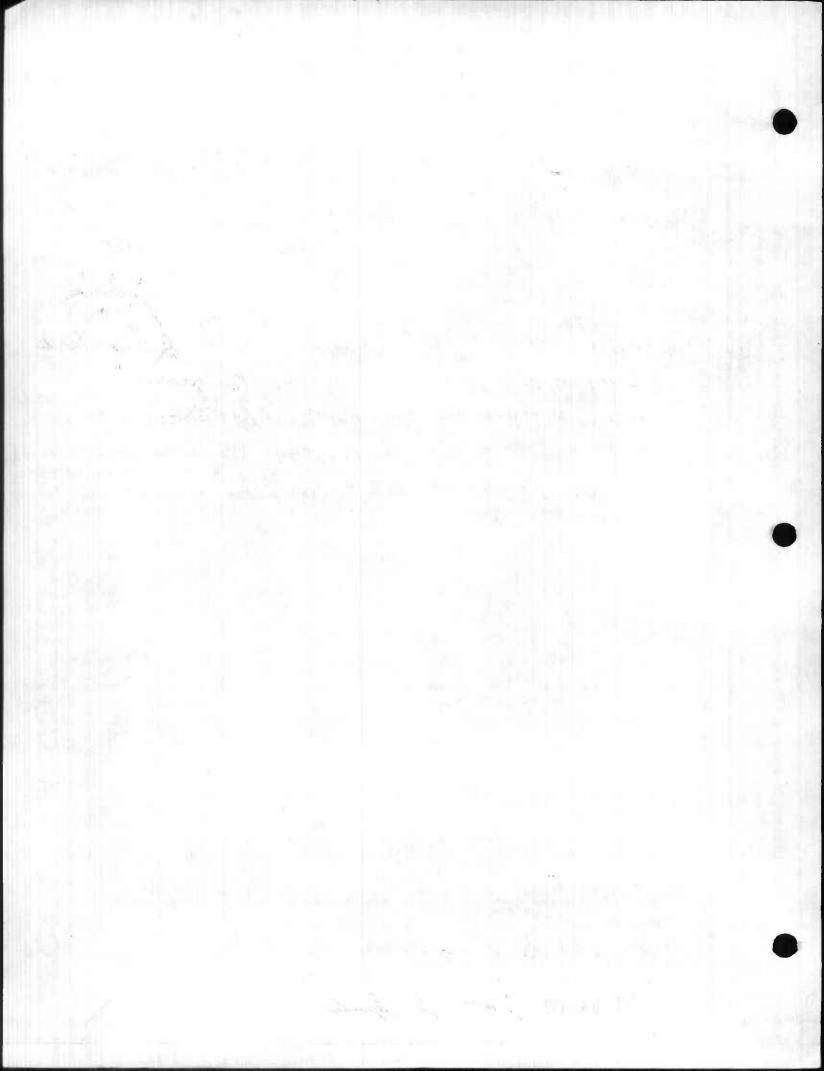
29c. License number O.C.M.E 29d. Date signed (Month, Day, Year) JULY 31, 1999

30. Name and address of person who completed cause of death (ttem 23m (Type, Print)

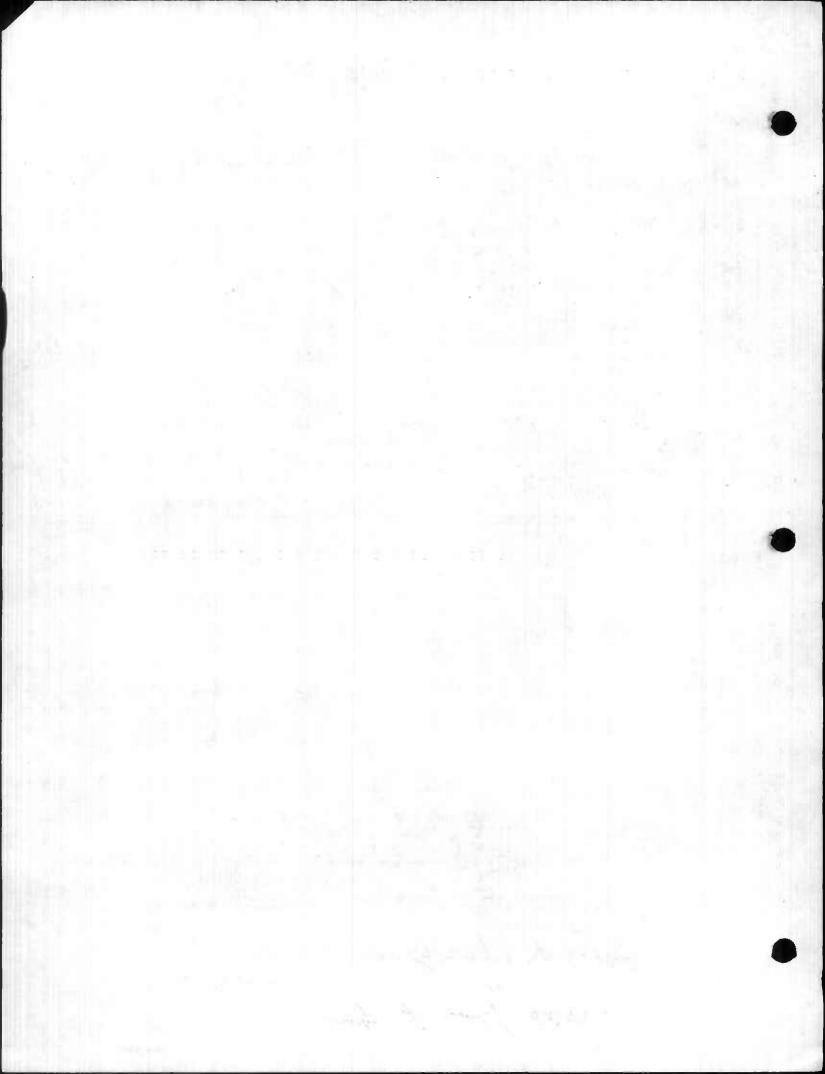
Radentz 111 Penn Street, Baltimore, Maryland 21201

32. Registrar's Signatura

State Registrar



Physician	1	. Decedent's Neme (First, Middle	28A-F	per M urph	und / Dep E 0 Ce	rtificate	e of	Death		2. Date of I Month JULY	Reg. N	-	Year	3. Time of 3:1	of Death
/Medica Examine	4.0	a Facility Name (If not institution		imber)	1				wn, or Lo	ocation of De		Ic. County			
Funeral Director		Social Security Number UNIX	6. Sex 1 □ M 2 □ F	7. Age (In yn	s. last birthday,	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of E	Birth Day, Year Z3	1961	9. Birthple County	ace (State	or Forei
28e-f show notified at	10	State 10b. County  Marylan	NA	10c. 0	City, Town or L	ocation Timo	re	,		/_			10	d. Inside (	
ifier death with the Ma r farms 23a or 28a-f e finer count te notified	10	3907 Fair	view A	tre.		10f. Zip	Code	2121	6		10g. C	Oltizen of V	What Counti	7	
urs a	à	1. Marital Status 1 ☑ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	Armed Fi	12. Was Decedent Ever in U,S. Armed Forces?  1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes:  13. Was Decedent of If Yes, specify Ci				lispanic Ori an, Mexican Specify:	gin? (Spi , Puerto	ecify Yes or I Rican, etc.)	No-		e - America ck, White, et :: B(		-
within then	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) 4H Gradu	College (	1-4or 5+)	(Give	dent's Usua kind of wor DO NOT us	k done	Kev				Har	usiness/Indu		Bat
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pes 1 end 2 of Health a if Itam 27 ie other tra		9a. Informant's Name/Reletions!  De. Method of Disposition  1 Description 2 Cremation  4 Donation 5 Other (Sc	Murphy 3 □Removal from		390 Place of Disp cemetery, cre	osition (Nammatory or ot	UV ne of	view	AV	Dete Sit	aH	nor	State, Zip (	aryl	212
Department Department Important: any Injury once	2	1. Signature of Funeral Service I		en		2. Name and	d Addre	ss of Fecilit	Kei	in A	R	Ker	Feu	etal	4
	2	3a. Pert1. Enter the disease, or	complications that	caused the de	ath. Do not en	ter the mode	e of dyir	ng, such as	cardiac	or respiratory	arrest,	more		Approxima	
Physician /Medical Examiner	tr	23a. Pert 1. Enter the disease, or shock, or heert tailure. List mmediate Cause (Finel lisease or condition esulting in death)	only one cause on	OTIC,	ALCOR	IOL A						ATIO			tween
/Medical Examiner	tr d	shock, or heert tailure. List of the shock, or heert tailure. List of the shock of	only one cause on	OTIC, Due to	A L C O H	quence of):						ATIO		Approxima Interval Be	tween
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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔾 🗅 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month 245 James E. McArthur 4a. Facility Nema (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth reneral ary and 8. Dete of Birth (Month, Dey, Year) 04 25 1933 5. Sociel Security Number If Under 1 Birthpiece (State or Foreign Country) 7. Age (In yrs. lest birthdey) 6 Sax Days 13€ M 2□ F 66 Yrs. 245-50-6039 North Carolina 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits 1 Yes 2 □ No Maryland N/A Baltimore City 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 4800 Yellowwood Avenue Apt T-05 21209 14. Race - Amarican indien, Bleck, White, etc. 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yas 2 ☒ No Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexican, Puerto Ricen, atc.) 1 Never Merried 2 Married if Yas, Give Yeer or Dates: 1 ☐ Yas 2 No Specity: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Truck Driver Transportation 9th 17. Fethar's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) James Arthur, Sr. Hattie Alston 19e. informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Irene McArthur/Wife 4800 Yellowwood Ave, Apt T-05, Baltimore, Md. 21209 20b. Place of Disposition (Name of cematery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burlel 2 Cremetion 3 Removel from Steta 4 ☐ Donetion 5 ☐ Othar (Specify) Woodlawn VIGOAla May 21. Signeture of Funeral Service Licenses 22. Nama and Address of Fecility William C. Brown Community Funeral Home 23a. Pert1. Enter the disease, or amplications that caused the death. Do not antar tha mode of dying, such as cardiac or raspiratory arrest, shock, or heart feilure. List only one cause on each line. 21217 Approximate interval Between Onset end Deeth Immediate Cause (Finel cerebra disaasa or condition resulting in death) edema Due to (or es e consequence of): non Sequentially tist conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events rasulting in deeth) Lest Due to (or as a conseque lett middle Due to (or es e consequence of) Pert ii. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 DUnknown 24b. Were eutopsy findings avellable prior to 24e. Wes en autopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medice! 26. Piece of Deeth (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yes 2 No 1 S Inpatient 2 □ ER/Outpetient 3 □ DOA 27. Menner of Death 28e. Dete of injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. injury et Work? 5 Pending investigation 1-DNaturei 1 ☐ Yes 2 ☐ No 2 Accident

ettending physician and for use es the bunal-transit certificete be executed P.O. Box 68760 ed by the detached signed b Records, peen page 2 certificate Division of Vital 

Physician/Medical þ Completed Be 10 in by t

Examiner Certification: pelli

**Physician** 

Examiner

**Funeral** 

Director

me 23e or 28e-f show

Bens .

"natural", or

Department of Health and Mental b Important: If Illum 27 is marked off any Injury or other traument

**Physician** /Medical

Examiner

Maryland 21215-0020

Baltimore,

Director

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Completed

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ANKA State

Medical

3 Sulcide

29e. Certifier

4 Homicide

(Check only

29b. Signatura and titla of certifier

ula

6 Could not be

Danway

29c. License number

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29d. Date signed (Month, Day, Year)

281. Location (Street and Number or Rural Route Number, City or Town, State)

MARYLAND GENERAL HOSPITAL

30. Name and eddress of person who completed ceuse of deeth (item 23e) (Type, Print)

BHATTI SARWAR 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture

AUG 04 1999

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

**DHMH 16 Rev 6/95** 

Registrar

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MelissA MOORE 7.15 AM 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Ravenwood Nursing& Rehab Center Baltimore N/A 7. Age (In yrs. last birthday) 26 yrs If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Yea Birthplace (State or Foreign Country) 1□M 2KTF Deys Yrs 216-84-9962 03 06 1973 Maryland Usual Residence of Decedent 10b Count 10c. City, Town or Location 10d. Inside City Limits Maryland N/A Baltimore City Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 741 N. Fulton Avenue 21217 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yas, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. Never Merried 2 Married 1 ☐ Yes 2 ☐XNo Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 9th Never employed 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas L. Moore Sylvia Dorsey 19a. informant's Name/Relationship (Type, Pnint) 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, State, Zip Code) William C. Brown Community Funeral Home 1206 W. North Avenue, Baltimore, Md. 21217 Genevieve Johnson/Aunt 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Date 1 Burial 2 □ Cremetion 3 □ Removal from State □ Donation 5 □ Other (Specify) 8/6/99 Baltimore, Maryland Mt. Zion Cemetery 22. Name and Address of Facility William C. Brown Community Funeral Home 1206 W. North Avnue, Baltimore, Md. 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on aech line. Approximata Interval Between Onset and Death Immediate Causa (Final disease or condition resulting in death) Dua to (or as a consequence of) Sequentially list conditions, if eny, laading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated avants resulting in death) Last Dua to (or as a consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably Unknown 24b. Were sutopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 20

**Physician** /Medical Examiner

Department of Important: If It eny injury or o

**Physician** 

/Medical

Examiner

10a State

**Funeral** 

Director

ral', or items 23a or 28a-f shore Examiner must be notified at

Peges 1 and 2 should be filed within 72 hours after death with I ment of Health and Mental Hygiene.
ant: if item 27 is marked other than "natural", or items 23a or: ury or other traumate event, the Medical Examples Trais to at ury or other traumate event, the Medical Examples.

Baltimore, Maryland 21215-0020

Director

Funeral

by

Completed

the Maryland

burial funeral

Examiner Physician/Medical þ Completed Be

Certification: To Medical

The law requires that the death certificete be executed physician s the burial signed by the certificate hes t lirector, page 2 s Hospital or Attending Physicien: '24 hours after death.'
Funeral Director: After this certifica 5 To the Hospital of within 24 hours at To the Funeral D completely filled!

Division of Vital Records, P.O. Box 68760,

State Registrar

**AUG** 04 1999

5 Panding

investigation

6 Could not be

32. Registrar's Signature

28a. Data of injury (Month, Day Year)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. injury et Work?

Certifying Physician: To tha bast of my knowledge, death occurred at the time, date and place, and due to tha cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated.

29c. License number

1 Yes

2 No

26. Place of Deeth (Check only one)

Other: 4 Jursing Home 5 Residence 6 Other (Specify)

28d. Describe how Injury occurred

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

1 Yas 2 No

25. Was case referred to medical examiner?

29b. Signature and title of certifie

31. Dete filed (Month, Day,

1 ☐ Yes

27. Manner of Death

1 Accident

3 Sulcide

29a. Cartifier

4 Homicide

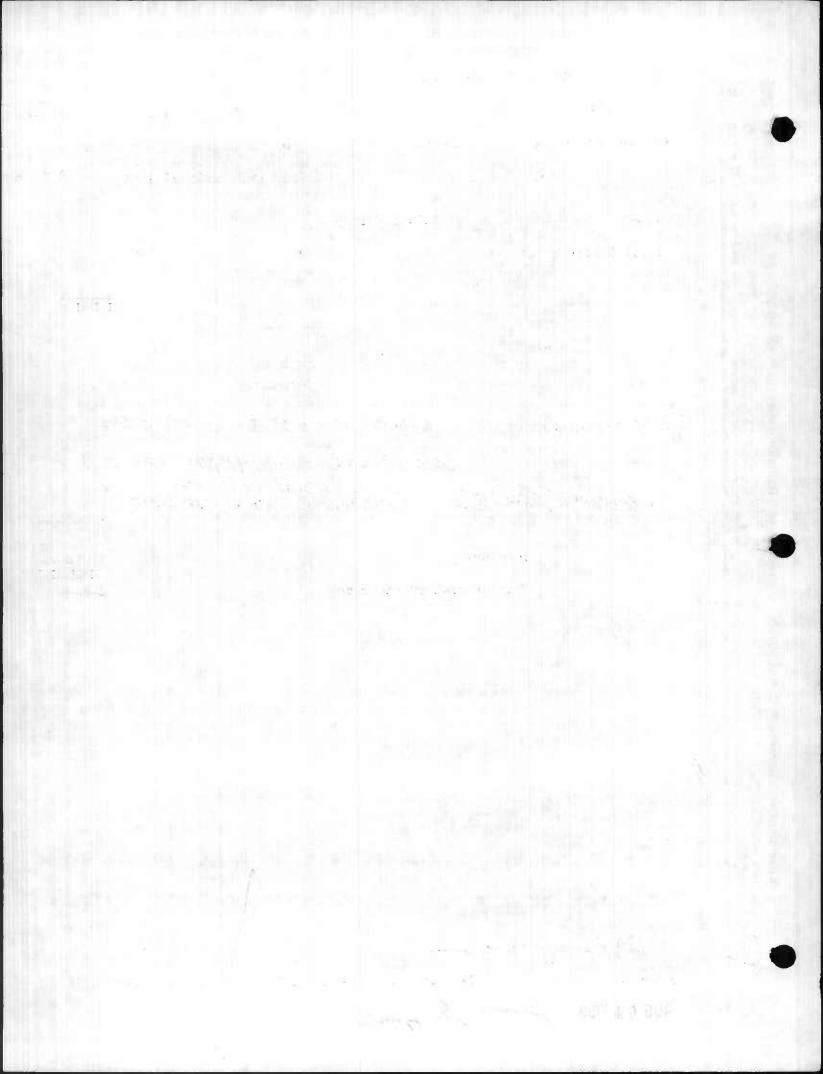
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State of Maryland / Department of Health and Mental Hygiene o

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ian	400	CABY		BOY		MA	ASTOOR		July 2	Day 22 1999	Yaar	15.27
cal ner	4a Fecility Name	(If not institution	n, give stre	et and number)				4b. City, Town, or			of Death	15:37
	Greate	r Balti	more	Medical	L Cent	er		Towso	n	R:	altin	nore
	5. Sociel Security	Number	6. Sex		ge (In yrs. las		If Under 1 Year Months Deys	If Under 24 Hrs	8. Date of Bi	rth	9. Birth	place (State or Foreign
	Navel Caritone	of Donadant	X	2 F		Yrs.		1 3	Jul	y 22,19	99	Marylar
	Usual Residence of 10a. Stata	10b. County	,		10c. City,	Town or Loc	ation				1	10d. Inside City Limits
	Maryland				S-	ilver	Spring					1 ☐ Yes 2 No
	-	umber			0.	LLVCI	10f. Zip Code			10g. Citizen of V	What Coul	ntry?
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		rried 2 Man	ried	Armed Forces? 1 ☐ Yes 2 🔀 If Yas, Giva Yeer or Dates:			Yes 2 No		to rican, etc.)	Specify	ck, White,	MINOLINI
		15. Decedan		on		16a. Deceda	ant's Usual Occu	pation		16b. Kind of Br		
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1	Adnan			Hyd	er			Momin	a		Mast	oor
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	6.6MC.	MHX	064		Jan Di	67011	V. CHAK	LES ST.	Towson,	W. 5	1204	
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		5 ☐ Other (S			6/1		POINT (	KMATORY	7/24/99	DALT	D. CI	on IT
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j	WA	Veas	K. Fla	W III		14	905 Yock	KA. BC	1270,012	21212 3	7	
	23a. Pert1. Enter shock, or ha	tha disaese, or art failura. List	r complicati t only ona c	ons that caused ause on aach li	d tha death. ina.	Do not ente	or the mode of dy	ing, such es cardie	c or respiratory	arrest,	1	Approximate Intervai Batween Onset and Death
	Immediata Causa	/Final										Onset and Death
- 1	disease or conditi resulting in death)	ion	a	Immatur:								l's hours
	disease or condition resulting in death)	ion	a		Due to (or	as a consequ						l's hours SINCE BIRTH
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Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other sign  25. Was case reference examiner?  1 Yes 20  27. Mannar of Dea 12 Accident 2 Homicide  29a. Certifier (Check only one)  30. Name and add 20. If any, leading the control of the contr	conditions, immediate serving or injury its Last served to medical serving or injury its Last served to medical livestificant conditions and livestificant conditions are livestificant conditions. The conditions are livestificant conditions are livestificant conditions are livestificant conditions. The conditions are livestificant conditions are livestificant conditions are livestificant conditions. The conditions are livestificant conditions are livestificant conditions are livestificant conditions. The conditions are livestificant conditions are livestificant conditions. The conditions are livestificant conditions are livestificant conditions are livestificant conditions. The conditions are livestificant conditions are livestificant conditions are livestificant conditions. The conditions are livestificant conditions are livestificant conditions are livestificant conditions. The conditions are livestificant conditions are livestificant conditions are livestificant conditions are livestificant conditions. The conditions are livestificant conditions are livestificant conditions are livestificant conditions. The conditions are livestificant conditions are livestificant conditions are livestificant conditions. The conditions are livestificant conditions are livestificant conditions are livestificant conditions are livestificant conditions. The conditions are livestificant conditions are livestificant conditions are livestificant conditions are livestificant conditions are livestificant conditions are livestificant conditions. The livestificant conditions are livestificant conditions are livestificant conditions are livestificant conditions are livestificant conditions are livestificant conditions are livestificant conditions are livestificant conditions are livestificant conditions are livestificant conditions are livestificant conditions are livestificant conditions are livestificant conditions are livestificant conditions are livestificant conditions are livestificant conditions are livestificant conditions are l	b	uting to death buting the buti	Due to (or a anial Due to (or a nial Due to (or	CYSTI as a consequ as a consequ ting in the un  R/Outpetient 28b. Time of Injury ne, farm, stre ledga, daath on and/or invo	C mass  uence of):  derlying cause given the state of the	26. Placa of Dether:  4 \( \text{Nursing} \)  In at tork?  Yes 2 \( \text{No} \)  In at the same place opinion, death occurs opinion, death occurs on the same place opinion.	24a. Waperline 24a. Waperline 24a. Waperline 24b. Chack only Home 5 Res 28d. Describe 28f. Location City or To	Yes 2 No s an autopsy omed?  Yes 2 No one) iidance 6 Oth how injury occur (Street and Numbers, State) a causa(s) and min, data and place, 29d. Date signe 7/23/9	24b. Wash of the state of the s	SINCE BIRTH  3 days  To the cause of death's shall be prior to morpletion of cause death?  The shall be prior to morpletion of cause death?  The shall be prior to morpletion of cause death?  The shall be prior to morpletion of cause death?



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Amended Item#19a perFH G774 8/4/99 EW Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Dev Month Year 12:09 AM CLARICE MC MILLION 1777 YINL 31 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street end number) 4c. County of Death Baltimore Bayview Med Center If Under 1 Year If Under 24 Hrs. Birthplaca (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours 1 M 3 X Yes. 218-18-8462 Usuel Residence of Deceden 14 01 M.D. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 X Yes 2 No Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 124 West Franklin Street 21201 11. Merital Status 12. Was Decedent Ever In U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced Black 16s. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home 12th grade NA Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edith Brooks John Green 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Romaine Harrir Baughter 6520 Eberle Drive apt 102, Balto Md 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20s Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 22. Name and Address of Facility 8/6/99 Randallstown MD 21. Signature of Funeral Service Licensee March F/H West 4300 Wabash Ave, Baltimore Md 21215 Approximata Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CARDIAC ARREST LOMINOLES disease or condition resulting in death) Due to (or as a consequence of): 24 HOURS CEPSIS Sequentially list conditions, if any, leeding to immediate causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or as a consequence of):

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

Examiner

**Funeral** 

Director

"natural", or Itama 23a or 28a-f show

ntal Hygiene. ed other than 'r svent, the Men

permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other treumstic svent and Injury or other treumstic svent ances.

Director

Funeral

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Completed

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the Maryland

filed within 72 hours after

altimore, Maryland 21215-0020

Examiner physician s the burial Physician/Medical 3 þ Sign Completed page i or Attending Physician: ster death. Director: After this certific Be edicai Certification: To

law requires that the death certificate be executed

He

68760

Box (

P.O.

Records.

Division of Vital

Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death?

ARTERY DISEASE CORONARY DEPENDENT VENTILATOR

1 Yes 25 No 3 Probably 4 Unknown 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24a. Wes en autopsy

25. Was case referred to medical

2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)

1 ☐ Yas 2月	.No	1 Depatient 2	☐ ER/Outpatient 3☐	DOA Other: 4E	Nursing Home	5 Residence 6 Other (Specify)
27. Manner of Deat 1 ØNatural 2 ☐ Accident	1		28b. Time of Injury	28c. Injury at Work?		d. Describe how injury occurred
3 ☐ Suicide 4 ☐ Homlcide	6 Could not b determined		nome, farm, street, farify)	ctory, office	28	f. Location (Street and Number or Rural Route Number, City or Town, Stete)
29a. Certifier	Cartifying Ph	velcien: To the best of my kn	owledge death occur	red at the time, date	e and place an	d due to the cause(s) and manner as stated

🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature end title of certifier 29c. License number

29d. Date signed (Month, Day, Year) July 31,1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HOSPITAL, BALTIMORE, MD HUDKINS DIAZ, A. JOHNS 31. Date filed (Month, Day, Year)

RES -000

State Registrar

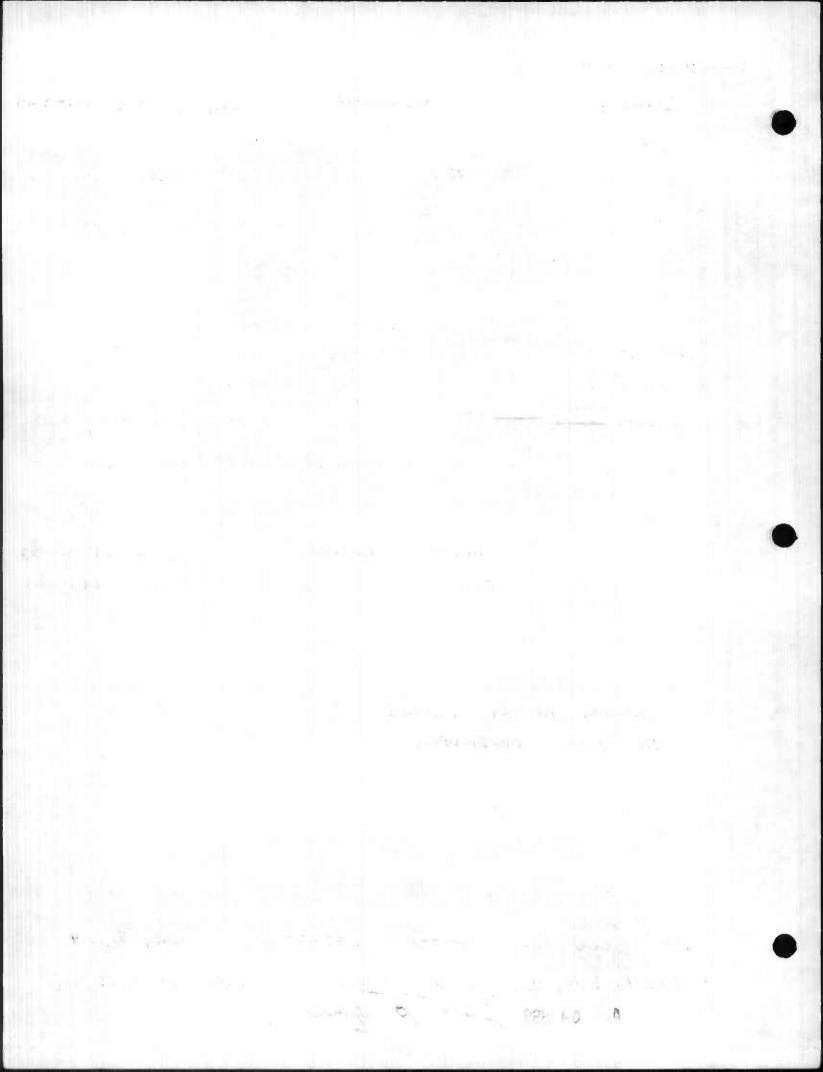
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State of Maryland / Department of Health and Mental Hygiene 99 244.79

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State Registrar

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Who completed cause of death (Hem 23e) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

4 1999

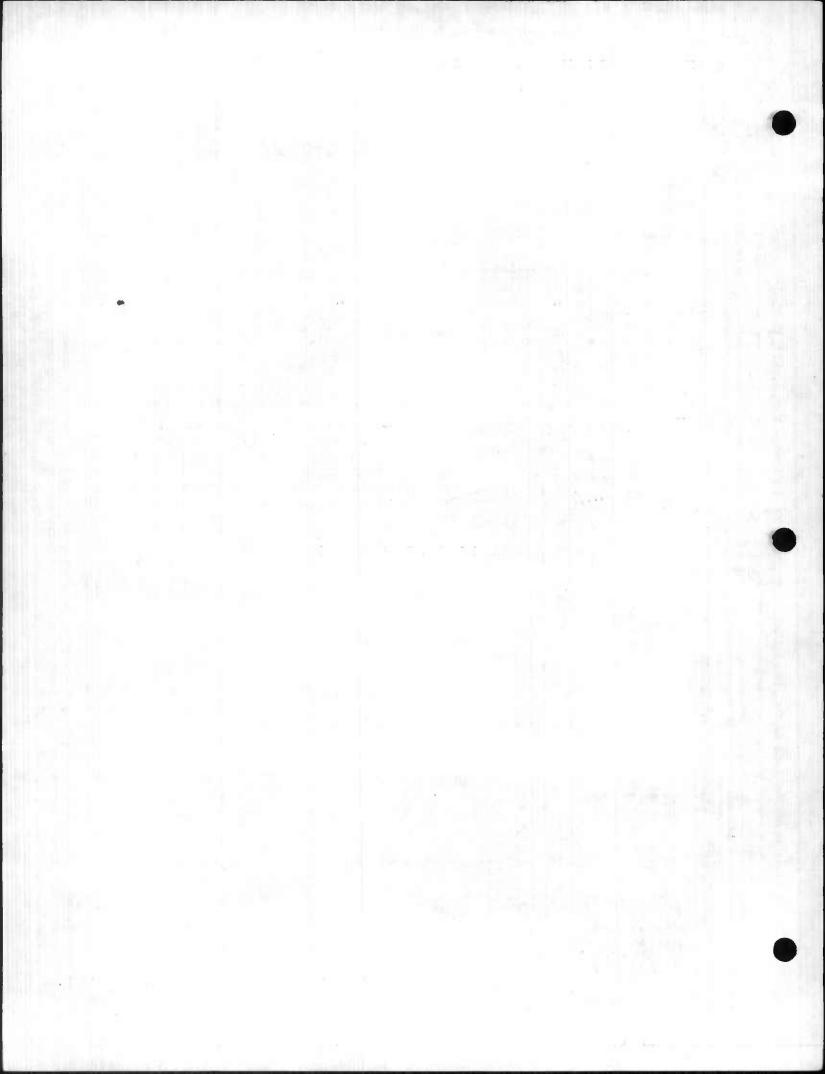
4. Aparksi

29c. License number

O.C.M.E

29d. Dete signed (Month, Day, Year)

JULY 24, 1999



## Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 3,1999 1307,M. Prestina Patricia Phillips August /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Baltimore Reisterstown 9 Jill Ct. If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) 9. Birthplece (Stete or Foreign Country)
Baltimore, Md 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 XF Yrs. November 27, 1944 Director 216-48-3997 Usual Residence of Decedent with the Maryland 10a. Stete 10b. County 10c. City, Town or Location ahow 10d. Inside City Limits the Medical Examiner must be notified at 1 ☐ Yes 2 No Md. Stevensville Funeral Director Queen Anne's 288-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Herne 23a or 21666 104 Touhey Drive U.S.A. death Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Meritel Stetus Wes Decedent Ever in U,S. Armed Forces? Bleck, White, etc. filed within 72 hours after 1 Never Merried 2 Merried 1 ☐ Yes 2 No If Yes, Give 21215-0020 9 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hyglene. Elementery/Secondery (0-12) College (1-4or 5+) Federal Gov't 12 Social Security Adm. Maryland 17. Father's Neme /First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Surnama) Department of Health and Mental Important: If Item 27 is marked or any Injury or other traumatic eve Pages 1 and 2 should be nent of Health and Mental Mary Gatley Preston Harry Phillips 19e. Informant's Neme/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) John M. Pollock - husband 104 Touhey Drive Stevensville, Md. Baltimore, 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition
1 ☐ Buriel 2 ☐ Crametion 3 ☐ Removel from State 20c. Location - City or Town, Stete 4 ☐ Donetion 5 ☐ Other (Specify) Aug. 4, 1999 Metro Crematory Baltimore, Md. 22. Name and Address of Facility
Eckhardt Funeral Chapel 21. Signature of Funeral Service Licensee 11605 Reisterstown Road Owings Mills, Md. Inter the disease, or complications that caused the daeth. Do not enter the mode of dying, such as cardiac or respiretory errest, at heert feilure. List only one cause on each line. Approximete Intarval Batween Onset and Death **Physician** /Medical Immediate Couse (Finel disease or condition resulting in daath) BrOIN Tumor Examiner Dua to (or as a consequence ot): Examiner Branch, 11s the burial-transit The lew requires that the deeth certificate be axecuted Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Diseesa or injury that initieled evants resulting in death) Last Bud Dua to (or as a consequence of): Box 68760 physicien Physician/Medical Due to (or es e consequanca of): 9 signed by the attending d be detached for use es Pert II. Other elanificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably Unknown Completed by 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? this certificate has 2 NO 1 Yes Division of Vital Attending Physician: director, 25. Was case rafarred to medical examiner? Be 26. Placa of Death (Check only ona) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1□ Yes → No funeral 28d. Describe how injury occurred 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accidant after deeth Director: / deeth the 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, State) To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th 3 Suicide 28e. Pleca of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledga, death occurred at the time, date and place, and due to the cause(s) and mannar es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. 29a. Certifiai Medical (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifie MO 30. Name end/addrays of parson who completed cause of death (Item 23a) (Type, Print) Clifford ely the Ste 225 ANUApolin 600 R-10 Solomor

**DHMH 16 Rev 6/95** 

State

Registrar

32. Registrer's Signeture

1999

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 8:20 AM turs ley August EVA 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE Home 10801/Ca If Under 24 Hrs. 8. Date of Birth
Min. (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country)
 VA 5. Social Security Number 6. Sex 1224257 Days 1 M 2 LF Months -06-1907 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 626 Woodbine Avenue 21204 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. 11. Merital Status Black, White, etc. 1 Never Merried 2 Merried 1 Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 5<sup>Elementery/Secondery (0-12)</sup> College (1-4or 5+) Homemaker Home 17. Father's Nema (First, Middle, Last) 18. Mothar's Neme (First, Middle, Maiden Surname) Catherine Brown Anthony Curtis Yowell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) 626 Woodbine Avenue, Balto., MD 21204 Mrs. Mary Pursley 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Greenmount Cemetery 8-4-99 Balto., MD 21. Signature of Europeal Service Licens Kaczorowski Funeral Home 1201 Dundalk Avenue, Balto., MD 21222 Pert1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximete Interval Between Onset and Death Immediata Cause (Final diseese or condition resulting in deeth) Urosepsis Due to (or es e consequence ot): Preumonia Due to (or as a consequence of): Years Cardiovascular Disease · Athenselevotic Part II. Other algrifficant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of seath? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings available prior to completion of ceuse of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 1 No 218 No 1 ☐ Yes 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menger of Death

**Physician** /Medical Examiner

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Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

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Directo

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**Funeral** 

Director

7 is merked other than "natural", or items 23s or 28s-f traumatic event, the Medical Examiner must be notified

Baitimore, Maryland 21215-0020

permit. Pages 1 and 2 should be tiled within 72 h. Department of Health and Mental hygiens. Important: If Item 27 is mented other the any injury or other treasment other the and the should be about the should be a should b

Examine Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Disaese or Injury that initieted events resulting in death) Last Physician/Medical

25. Wes cesa rafarrad to medicel examiner? 1 Yes 2 No

28a. Deta of Injury (Month, Day Year)

28c. Injury et Work?

28d. Describe how injury occurred

1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

6 Could not be determined 28e. Plece of Injury - At homa, farm, street, fectory, office building, atc. (Specify) 4 ☐ Homicide 29a. Certifier

E. Will II M.D.

32. Registrer's Signeture

1 Certifying Physician: To the best of my knowledga, death occurred at the tima, data and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mennar stated.

29b. Signatura and title of certifier

1 Netural

2 Accident

3 ☐ Suicide

(Check only one)

29c. License number D41365

29d. Dete signed (Month, Day, Year) August 2, 1999

30. Name and addrass of person who completed causa of daath (Item 23a) (Type, Print) GLOVGE E, WILLS THE TU.

1999 4

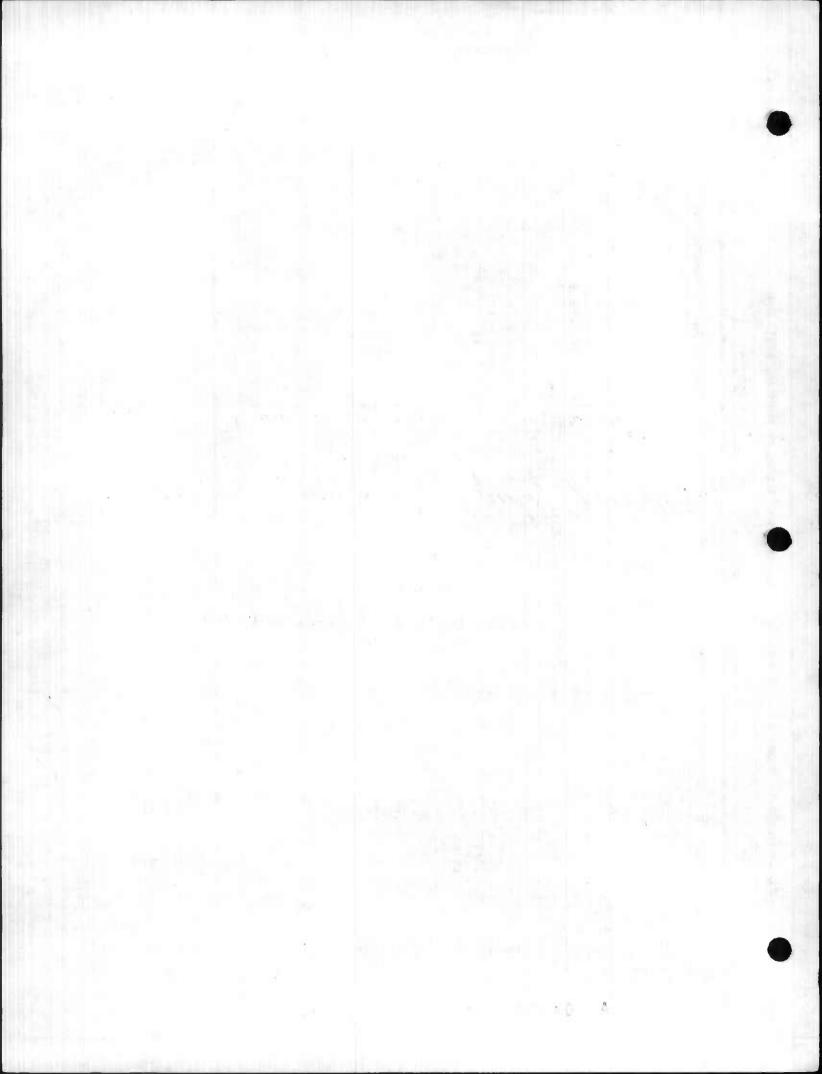
100 North Broadway 21231

State Registrar

DHMH 16 Rev 6/95

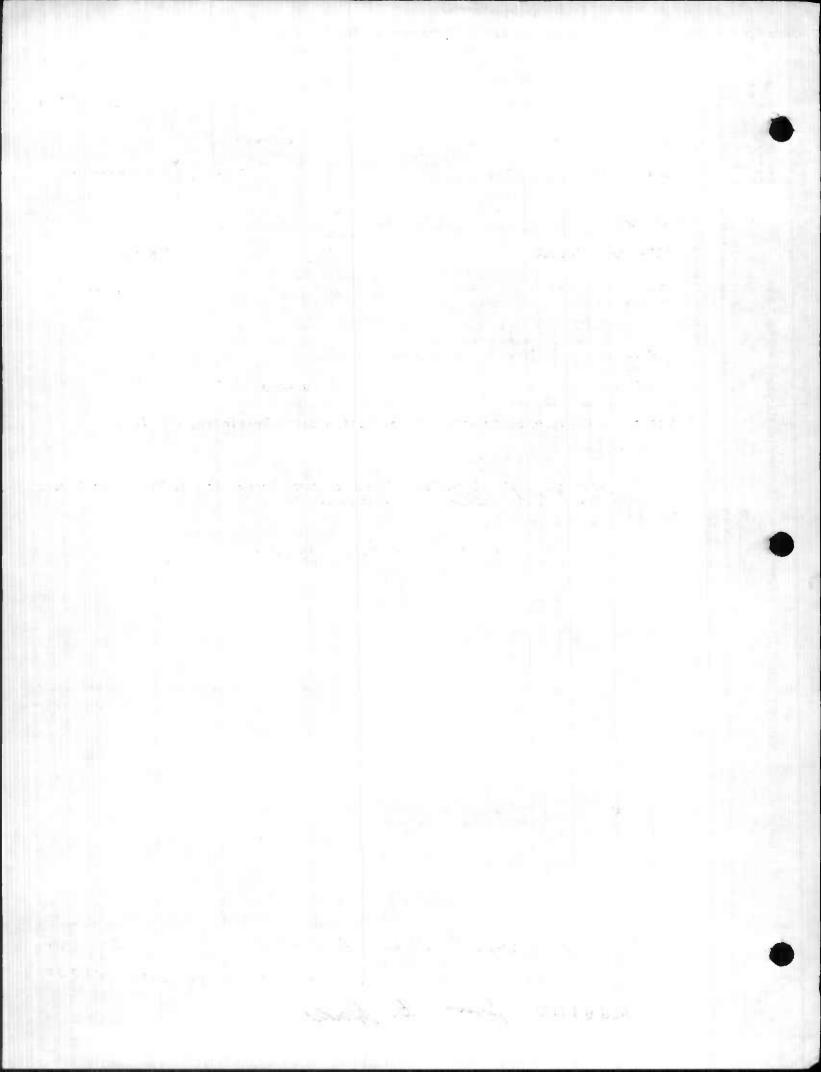
5 Pending investigation

**ORIGINAL** 



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1005 Month **Physician** 1050 Prince Din /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore Hospital Harber Center If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 X 76 Yrs. 215-02-2156 July 1, 1923 Director Maryland Usual Residence of Deceden death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ahow item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Directo Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21230 1213 Light Street U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Spacify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or iter 1 X Never Married 2 Married Specify: BLack 1 ☐ Yas 2 1 No Baltimore, Maryland 21215-0020 Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedant's Education 16a. Decedent's Usual Occupation. (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elemantary/Secondary (0-12) College (1-4or 5+) None None None 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) unknown unknown 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Harbor Inn Convelescent Center 1213 Light Street, Baltimore, MD 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) in state 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Director Ronald S State Anatomy Board, 655 W. Baltimore Street will TUBEL) Baltimore, MD 21201 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock or haart failure. List only ona causa on each line. Approximata Interval Between Onset and Death **Physician** Bilateral /Medical Immediate Cause (Final Bacteria preumonia disease or condition resulting in death) Examiner Due to (or as a consaquance of) Examiner sician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in daath) Last Due to (or as a consaquance of) Division of Vital Records, P.O. Box 68760, physician Physician/Medicai the Due to (or as a consequence of): 88 BSI Part II. Other stgniffcant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contributa to the cause of death? detached signed by t d be detach 3 Probably 4 WUnknown 1 Yes 2 No þ 24b. Were autopsy findings available prior to completion of cause of daeth? 24a. Was an autopsy parformed? Completed peen has 1 ☐ Yes 2 € No 1 Yas 2 No certificate Hospital or Attending Physician: director. Be 25. Was casa raferrad to medical 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3 DOA Aftar this funeral 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Natural 5 Pending Injury 24 hours after death. 1 Yes 2 No 2 Accident Investigation 6 Could not be datermined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicida 1 🗹 Certifying Physician: To the best of my knowledga, daath occurred at tha tima, data and placa, and dua to tha cause(s) and manner as stated. Medicai 29a. Cartifier To the Hosp within 24 ho To the Fune completely f (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who complated cause of death (Itam 23a) (Type, Print) BALTIMORE, MO 21225 HANOUER ST. ISMAIL 3001 5. BOBAT 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State AUG 0 4 1999 Registrar



MAS

8:55 PM

July 29,1999

Lillian Reich

State Registrar 31. Date filed (Month, Day, Year)

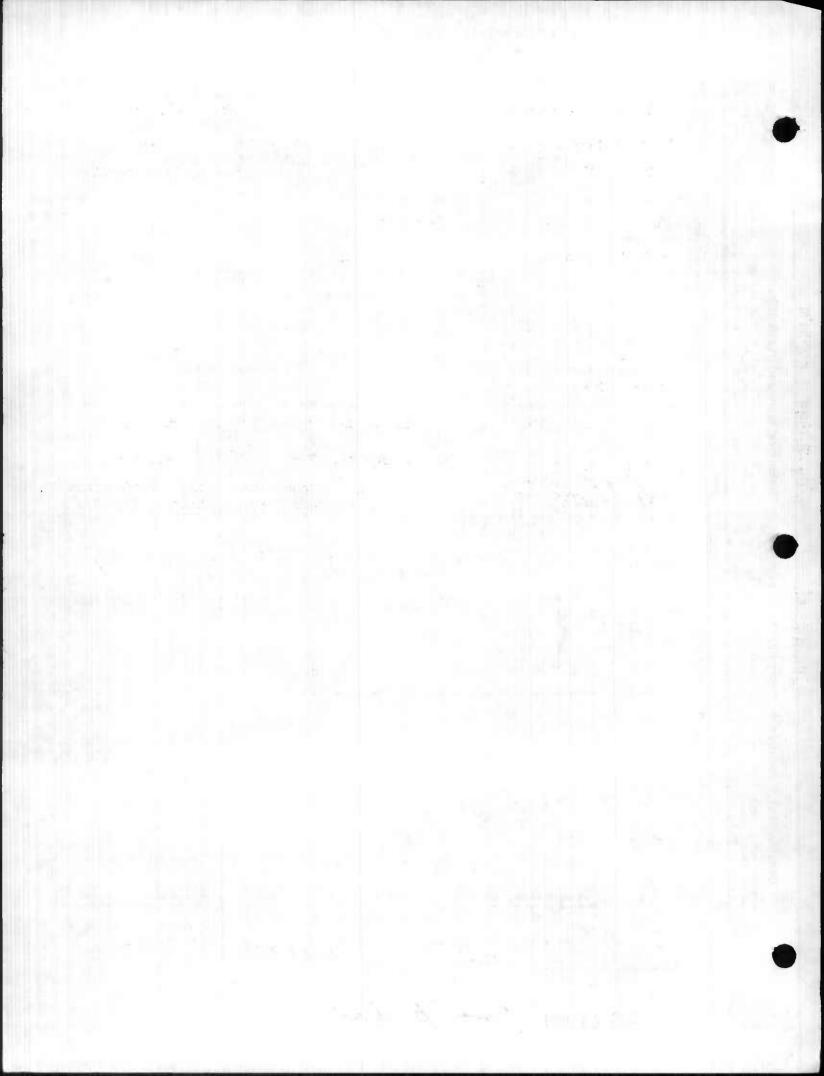
AUG 04 1999

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

. A . / 1 (0 201

egistrar's Signature & Spork



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Month 10.3 Mary Ann Robinson Mugust 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Stella Maris Hospice @ Mercy Hospital N/A Baltimore If Undar 24 Hrs. Hours Min. 8. Data of Birth (Month, Day, Year)
DEC 21, 19 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (Stata or Foraign Country) 1 Strict Days 1□ M 2GF 185-28-9878 73 of Columbia Usual Residence of Decedent 10e State 10b. County 10c. City. Town or Location 10d. inside City Limits 1 XYes 2 □ No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 524 N. Charles Street 21201 USA 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Giva Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, 11 Marital Status Black. White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 8 Waitress Restaurant 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) William Mathias Benezett Emma May Richardson 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 162 Factory Mill Rd. Bumpass, VA 23024 ce of Disposition (Name of Date 20c. Location - City or Town, State Anne W. Kersey/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cematery, crematory or other place) 1 ☐ Burial 2 ☐ Clemation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) Metro Crematory, Inc. 08/03/99 Baltimore, MD 21. Signature of Jungral Service Licentu 22. Name and Address of Eacility Cremation Society of Maryland, Inc. 21 Edward Frederick Rd. Baltimore, MD 21228 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death Immediate Cause (Final disaasa or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 Yes 2 No 24b. Were eutopsy findings available prior to completion of ceuse of death? 24e. Wes en eutopsy 2 No 1 ☐ Yas 2 ☐ No 1 Ves 25. Was cese referred to medical 26. Place of Death (Check only one STELLA MARIS AT MERC) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) HOSpick 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how injury occurred 27. Manner of Death 28b. Time of 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, straat, factory, office building, etc. (Specify) 4 Homicide

physicien and the buriel-transit that the death certificete be executed Division of Vital Records, P.O. Box 68760, 88 use ped i page 2 certificete Hospital or Attending Physician: 24 hours effer death. Funeral Director: After this certifice director. funeral

**Physician** 

/Medical

**Examiner** 

Directo

Funeral

þ

Completed

**Funeral** 

Director

the Meryland

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Meryla Department of Health end Menlel Hyglene. Important: If item 27 is marked other than "naturel", or items 23a or 23e-f ehow with figury or other treumatic event, it a Medical Examiner must be notified an once.

**Physician** /Medical

Examiner

Maryland 21215-0020

Baltimore,

Physician/Medical þ Completed Be 2 Certification:

Examiner

29a. Certifier (Check only one) Medical

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifit

29c. License number

29d. Date signed (Month, Day, Year)

M

PI , BAltiMORE,

30. Name and addrass of person who completed ceuse of death (Item 23a) (Type, Print)

DAVID RISE BERG 30/ ST

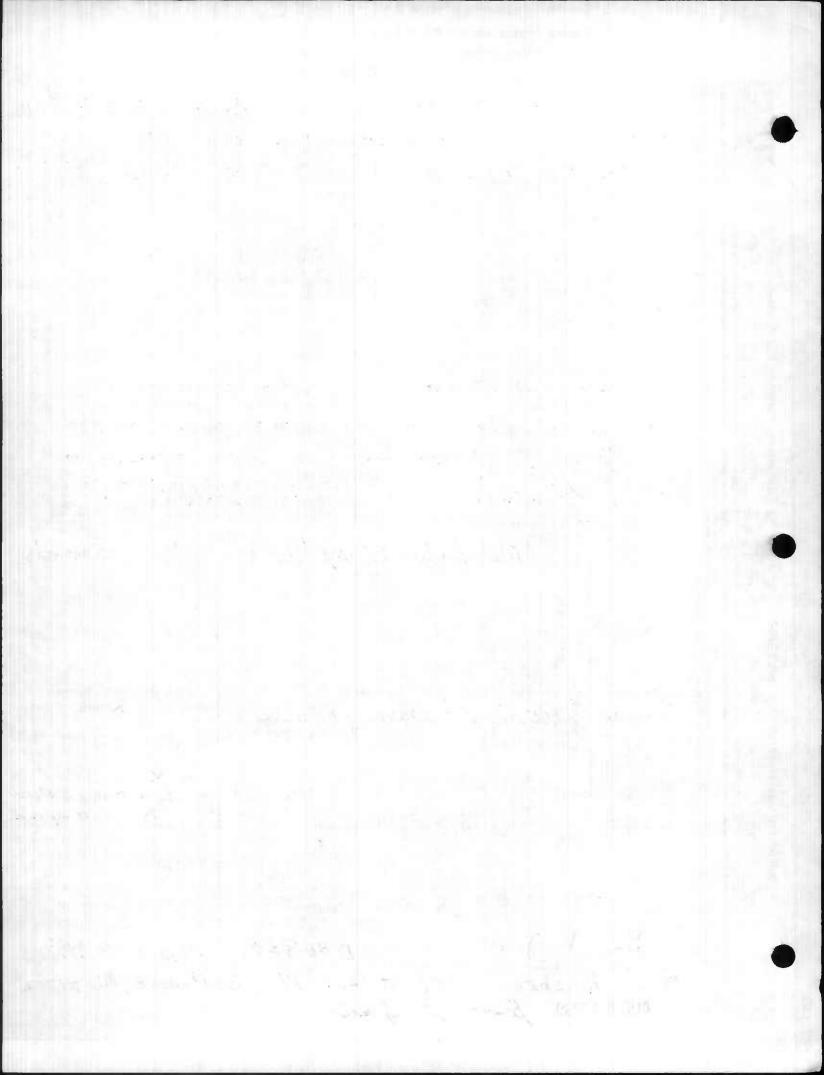
32. Registrar's Signature

State Registrar

6

5

To the Hospital or within 24 hours aft To the Funeral Di completely filled in



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		ctate of marylant		te of Death		g. No. 99	24485
Physician /Medical	1. Deceden 's Name (First, Middle, Las	J. Sade	cki		2. Date of Death Month	3,194	3. Time of Death
Examiner	4a Facility Name (If not institution, give	street and number)	/	4b. City, Town, or	Location of Death	4c. County of C	Move
Funeral Director	5. Social Security Number  213-68-43/1  Usuel Residence of Decedent	M 200 F 7. Age (in yes, in	Yrs. If Und Months	er 1 Year   If Under 24 Hrs Days Hours Min.	8. Date of Birth Month, Day,	Venr) 1953 9.	Birthplace (State or Foreign Country)
with the Meryland a or 28a-f ahow be notified at	10a. Stale 10b. County	10c. City	, Town or Location				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
vith the Mer or 28a-f all be notified	10e. Street and Number	more 1	100d Lav	ip Code	10	o. Citizen of Wha	
th with	3735 Qui	( avenu	10	2/20	7	U	54
020  ours after death with the Merylar all, or Name 23a or 28a-f ahow  examiner must be notified at by Funeral Director		12. Was Decedent Ever in U,S Armed Forces?/ 1 Yes 2 Wo If Yes, Give	S. 13. Was Dec	edent of Hispanic Origin? (Secify Cuban, Mexican, Puerl	specify Yes or No- to Rican, etc.)		American Indian, Vhite, etc.
	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Edu	Year or Dates:	16a. Decedent's Us	/	11	6b. Kind of Busin	NULL
T C 1 2 4	(Specify only highest grad	College (1-4or 5+)	(Give kind of v	ork done during most of wo	rking	Land	scape .
aryjand 212: should be filed within of Mental Hygiens. marked other than imatic avent, the H	17. Father's Name (First, Middle, Last)	JNK		18. Mother's Na	me (First, Middle, M	laiden Sumame)	INK
Maryland d 2 should be file th and Mental Hy ?? Is marked oth traumatic avent	194 Informant's Neme/Relationship (T	ppe, Print) CULL)	19b, Mailing Addre	as (Street and Number or Re	ural Route Number,	City or Town, Sta	te, Zip Code)
Pages 1 and 2 nent of Health mit if Nem 27 iny or other tr	20a. Method of Disposition  1 Burial 2 Cremetion 3 1  4 Donation 5 Other (Specify,	Removel from State / 6	ace of Disposition (Nometery, crematory of	ame of other place)	Date 2	Oc. Location - City	or Town, State
Baltimore,	21. Signature of Funeral Service Licens		22. Name :	and Address of Facility  BUT P. W	ylie h	inesal	Hone PA
	23a. Part 1. Enter the disease, or composhock, or heart failure. List only of	cations that caused the death.	. Do not enter the mo	de of dying, such as cardia	or respiratory arre	BULL	Approximete
Physician	shock, or heart failure. List only o	ne cause on each line.					Interval Between Onset and Deeth
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a. Squamers  Due to (or	as a consequence of		phayn		lyr.
8760, sate be executed shystelan and the burial-transit dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or	as a consequence of	):			
6876( filcate be g physicia as the bur	resulting in death) Last						
Box eath cert for use		d					
that the death certified by the attending detached for use at // Physician/Me		ntributing 10 death but not resul	iting in the underlying	cause given in Pert I.			Probably 4 Unknown
If Records, P.O. Box The law requires that the death cent tata has been signed by the attendin page 2 should be detached for use. Completed by Physiclan/M					24a. Was ar perform		4b. Were autopsy findings available prior to completion of cause of death?
eff the page					1 ☐ Ye	s 2E No	1□ Yes 2☑No
of Vital F Physician: The this certificats ral director, pag ; To Be Co	25. Was case referred to medical examiner?	lospital:		Other	ath (Check only one	-	
O £ 5	27. Manger of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)  28b. Time of Injury at Work?			tome 5 li2 Aesidence 6 □Other (Specify)  28d. Describe how injury occurred		
Division of To the Hospital or Attending P within 24 hours after death. To the Funeral Director: Affact completely filled in by the funeral Medical Certification:	3 Suicide 6 Could not be determined				28f. Location (Str City or Town	or Rural Route Number,	
To the Hospital or within 24 hours after To the Funeral Dir completely filled in Medical Cert	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my know ner: On the basis of examinati and manner stated.	rledge, death occurre on and/or investigation	d at the time, date and place n, in my opinion, death occu	a, and due to the ca urred at the time, da	use(s) and manne te and place, and	or as stated. due to the cause(s)
To the comp	29b. Signature and title of certifier		2	9c. License number	29	d. Dete signed (A	fonth, Day, Year)
	ma	_ MD		D40850	1	regnot 4	1999
	30. Name and address of person who or	empleted cause of death (Item	23a) (Type, Print)	AVE BAU	TIMUNE		
State Registrar	31. Date filed ADG Day Year 999	32. Registrar's Signatu	1	uls :			*

AHS

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Shup 9 PM Esther 0. Jul /Medical 4b. City, Town, or Location of Deeth 4a Fecility Name (If not institution, give street end number) 4c. County of Death Examiner Regional Prince George's Laurel Hospital Laurel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** 1□M 2√F Yrs. Director 216-32-4678 May 25, 1904 Wisconsin Usual Residence of Decedent with the Maryland 10a Stefe 10b. County 10c. City, Town or Location 10d. fnside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinar must be notified at 1 Ves 2 □ No MD Prince George's Director Laurel 10e. Streef and Number 10f. Zip Code 10g. Citizen of What Country? 20707 14200 Laurel Park Drive USA Funeral death 12. Wes Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☒No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. permit. Peges 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hyglens. Insportant: if Item 27 is merked other than "natural", or then any Injury or other traumatic event. the Mental Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3€ Widowed 4 Divorcad White Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 18b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Laundry Department Nursing Home 6 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Otto Ostrich Agnes UNK. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2830 NE 43rd St. Ocala, Helen E. North/Daughter FL 34479 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 Donation 5. Other (Specify) Metro Crematory, Inc. 8/2/99 | Baltimore, MD 21. Signature General Service Lights 22. Name and Address of Facility Cremation Society of MD, Inc. Gregorchik Edward 299 Frederick Road Baltimore, MD 21228 23a. Part 1. Enter the disease, ir complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ahock, or heart failure. Let only one cause on each line. Approximate Interval Between Onset and Death **Physician** Cardiac arrest /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Coronary artery disease Examiner physician and the bunal-transit Sequentially list condiflons, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Due to (or as a consequenca of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? signed by t cerebral vascular accident 2 8 No 3 ☐ Probably 4 ☐ Unknown by 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Was an autopsy 20 No 1 Yea 1 Yes 2 No Division of Vital Hospital or Attending Physician: 24 hours efter death. funeral director, 25. Wea case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Aftar 1 ANatural 2 Accident 5 Pending ofter death. Director: Af 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours e Certifying Phyafcfan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the Vithin 2 29d. Dafe signed (Month, Day, Year) 29b. Signature and title of centiles 29c. License number

Prince George St. Laurel, MD 20707

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

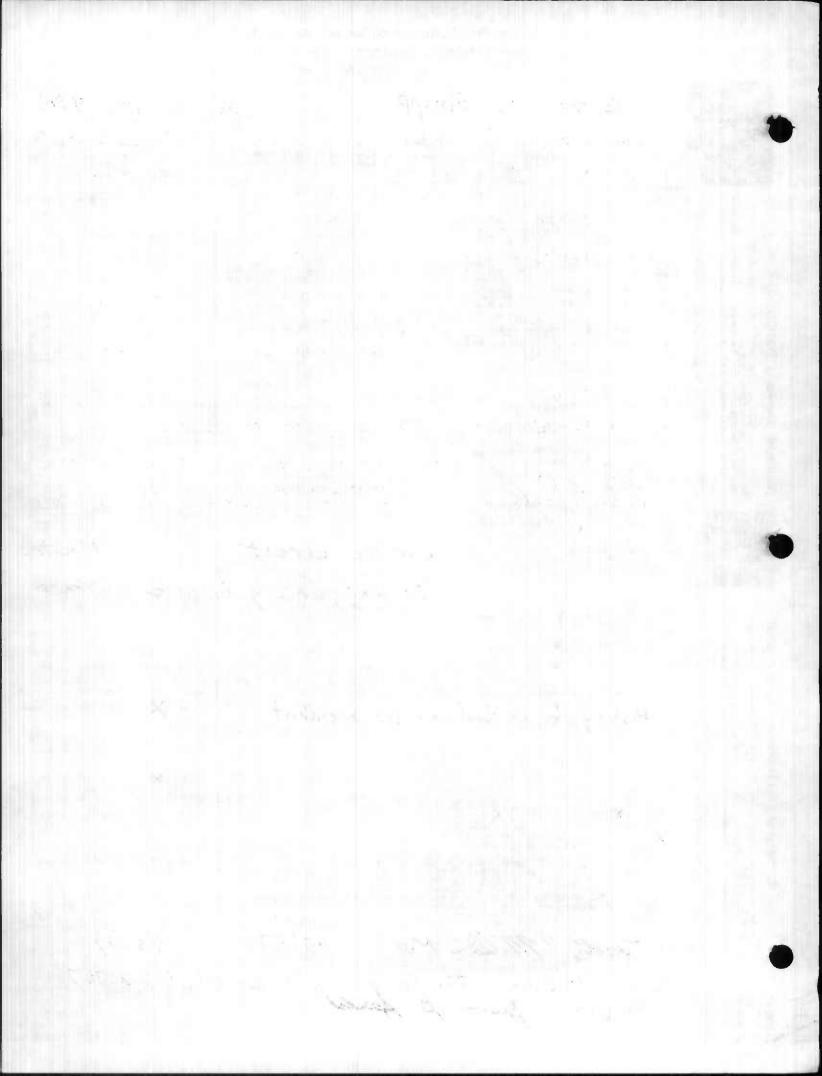
31. Date filed (Month, Day, Year)

32. Registrar's Signatur

Stre

DHMH 16 Rev 6/95

State Registrar



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3 Time of Deeth 2. Dete of Deeth EUGENE ABL 1999 8:12 BW 2014 31 4a. Fecility Neme (If not institution, give street end number) 4c. County of Deeth 4b. City, Town, or Location of Deeth 5. Sociel Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 4026 7. Age (In yrs. lest birthday) Birthplece (Stete or Foreign Country) Months DE M 2 F Yrs 257 46 043 FEB.17 GRORGI Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 28 No MARNERO HARFORD JOPPATOWNS 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? .S.A 203 OURT 91082 11. Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, spacify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: 3 Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) EXECUTIVE UNDERWRITER 124RS HARTFORD INSURANCE 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) ARL O-STAPP Gibboney 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 91082 DORIS H. TAPIZ 203 KANS MARYLAND JOPPAlown 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 22. Name end Address of Fecility 20a. Method of Disposition Dete 20c. Location - City or Town, Stete RU6-2 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 Qonetion 5 Other (Specify) 1999 FORST HILL I BRYLEW 21. Signature of Funeral Service Licensee - BELATIR P.A. EVANS FUNDRAL! -LEJAH-3 NEWPORT DRIVE FORDS PRYLAND 23e. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one cause on pech line. Approximete Intervel Between Onset end Deeth Immediate Cause (Final disease or condition resulting in deeth) Due to (or es e consequence of): Penal Failure Sequentielly list conditions, if eny, leading to Immediate cause. Enter Underlying Couse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): Pert II. Other eignificent conditione contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably ₹ Unknown 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Mon Insulin Operadent Dighter Heral Foilure 2 No 1 Tyes 1 ☐ Yes 2 ☐ No provic 25. Wes case referred to medical exeminer?

**Physician** /Medical Examiner

permit. Page Depertment of Important: If any injury or once.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

by

Completed

Be 2

Pages 1 end 2 should be filed within 72 hours efter death with the Maryla nent of Health and Mentel Hydene. next effect 21s marked other than "natural", or items 23s or 28s-1 shownt: If item 27 is marked other than "natural", or items bo notified a ury or other traumatic event, its wacteral Examiner must be notified as

21215-0020

Maryland

Baltimore,

the Maryland

The law requires that the death certificete be executed bunel-tran and physician s the buriel Box 68760 Division of Vital Records, P.O. É certificate To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifical completely filled in by the funeral director,

Examiner Physician/Medical þ Completed Be Certification: To

edicai

31. Dete filed (Month, Dey, Yeer) State

1 Yes 2 No 27. Menner of Deeth

Neturel 2 Accident

3 ☐ SuicIde

29a. Certifier (Check only one)

4 - Homicide

29b. Signature and title of cast

5 Pending Investigetion

6 Could not be determined

30. Name end eddress of pe of beeth (Item 23e) (Type, Print) on who completed an

143 W 32. Registrer's Signature

Hospital: ► Inpatient 2 □ ER/Outpatient 3 □ DOA

28b. Time of

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28e. Date of Injury (Month, Dey Yeer)

impledon

28c. injury et Work?

Text Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, death occurred et the time, dete end plece, end due to the ceuse(s) end menner steted.

29c. License number

1 Yes 2 No

26. Piece of Deeth (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

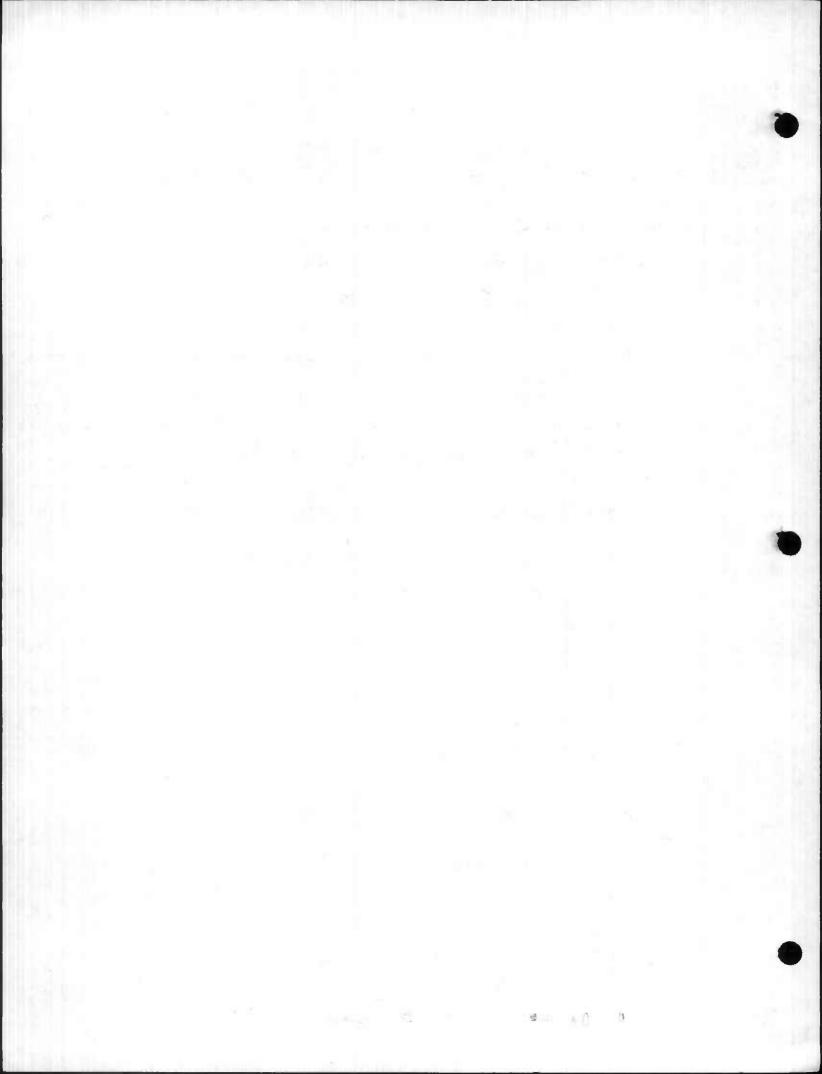
28d. Describe how injury occurred

28f. Location (Street end Number or Rurel Route Number, City or Town, Stefe)

29d Date signed (Month, Day, Year)

DHMH 16 Rev 6/95

Registrar



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Month Dev Yes 3:02 PM 1999 EDWARD E SCHLEIGH AUG. 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street end number) 4c. County of Deeth If Under 24 Hrs. 8. ( BALTIMORE ST. JOSEPH 5. Social Security Number CENTER MEDICAL 7. Age (In yrs. last birthday) If Under 1 Year 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Min. 12M 2□ F Hours 215-10-5683 MD Usuai Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No PARK VILLE MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8917 21234 U.S.A. 14. Race - American Indian, EMLA AVE 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces? 1 Yas 2 No If Yes, Give Year or Detas: Bleck, White, etc. 1 Never Merried 2 Merried 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE ARMY 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) t6b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) MAINTENENCE GENERAL MOTORS 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) ELIZABETH C. ENGLERRECHT EDWARD SCHLEIGH 19e. Intormant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) PARKVILLE MD. City or Town, Stete MARY SCHLEIGH ISPOUSE 8917 EMLA AVE. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Removei from Stete AUG. SI 4 ☐ Donation 5 ☐ Other (Specify) MORELAND MEM. PARK PARKVILLE, MD 1999 22. Name and Address of Facility EVANS FUNERAL CHAPEL 21. Signature of Fuñerai Service Liceosee PARKVILLE ND. 8800 HARFORD RD. 21234 23a. Part . Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximete Intervei Between Onset and Death Immediete Cause (Finai disease or condition resulting in death) DSERSIS Due to (or as e consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or as e consequence of): 23b. Did tobacco usa contributa to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings evailable prior to completion of cause of death? 24a. Was an autopsy performed?

**Physician** Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

2

Completed

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**Funeral** 

Director

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parmit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If flem 27 Is marked other eny Injury or other traumatic event, pages.

Maryland 21215-0020

Baltimore,

Examiner

physician end the burial-transit

by Completed 8 10

signed b Deed a certificate this funeral After in 24 hours after death.
the Funerel Director: After the Funerel Director. Attending

Box 68760. Physician/Medical P.O. Records. Division of Vital

State Registrar **DHMH 16 Rev 6/95** 

Within 2

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Vas 2 No 1 ☐ Yes 2 ₽ No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitei: 1 ☐ Inpatient 2 ☐ ER/Outpatien1 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Routa Number, City or Town, Stele) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, term, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted.

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

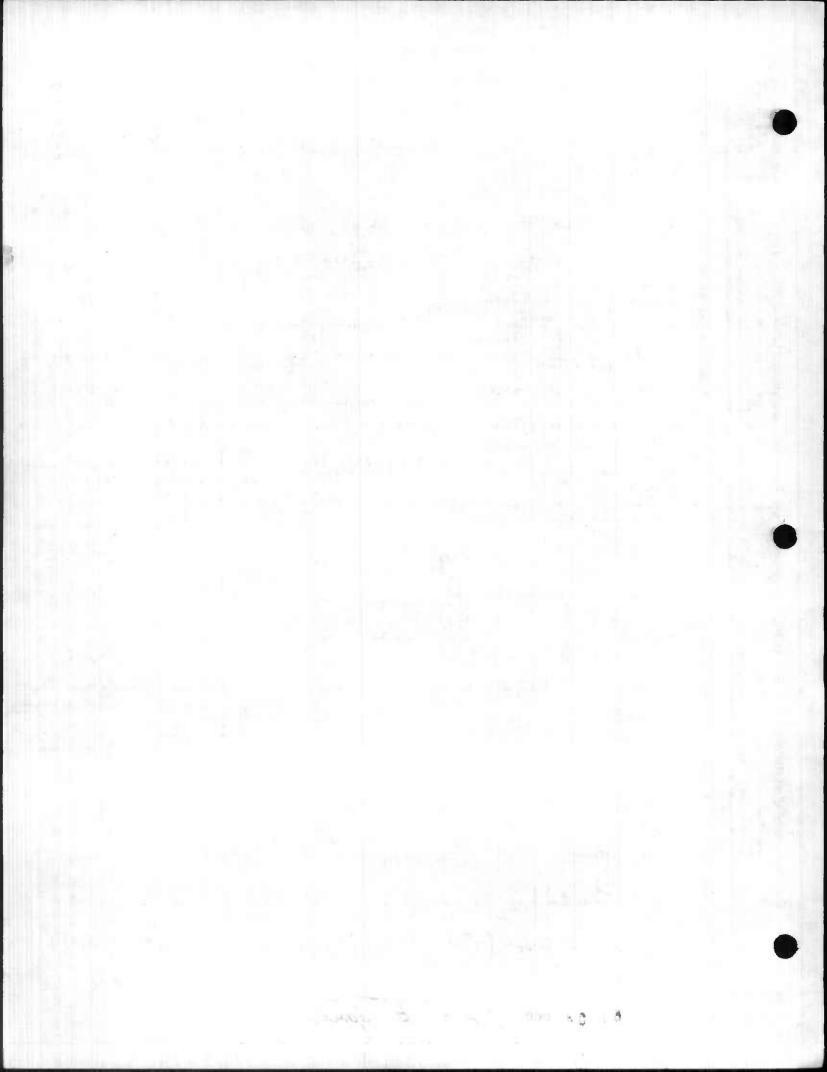
9512 Harbard Re Baltimer, MD 21234, Lise Satterfield MD

31. Date filed (Month, Day, Year)

29b. Signature and little of certifier

32. Registrer's Signeture

**ORIGINAL** 



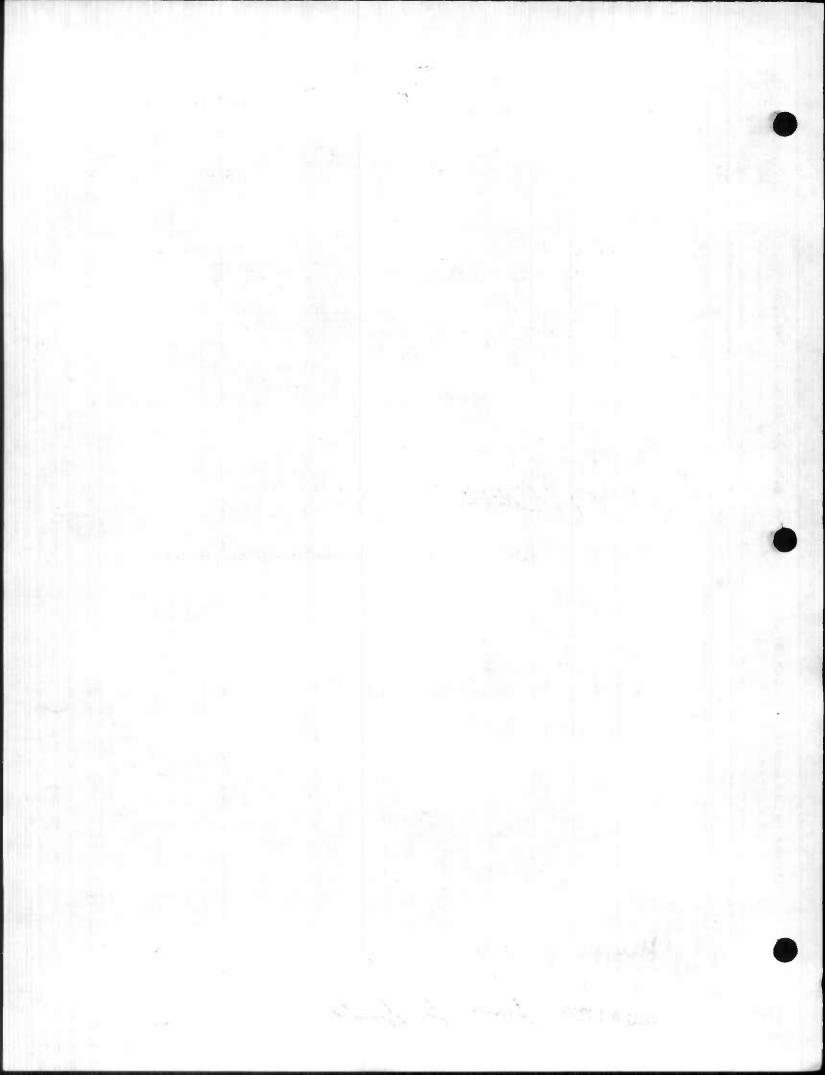
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	207 4 4		Ronald S. Wade, Director State Anatomy Board, 655 W. Baltimore St. Baltimore, MD 21201														
	Physician /Medical Examiner	liner	Immediata Cause (Final disease or condition resulting in death)		. ATH		to (or as a c		ence of):	B	miss	MSCU	is	- Dis	जार इ	1 1 1	
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	To the Hospital or Attending the Hospital or Attending the Hours after death.  To the Funeral infector: A completely filled in by the formation of the formatio	edical C	29a. Certifier 1 0 (Check only one)	Certifying Ph Medical Exam	yalclan: To the	best of my asis of exa- nar stated.	knowledge, mination and	, death o	ccurred at the stigation, in my	time	, date and pla nion, death or	ace, and due	to the o	cause(s) and date and pla	d manner a	as stated. ue to the ca	luse(s)
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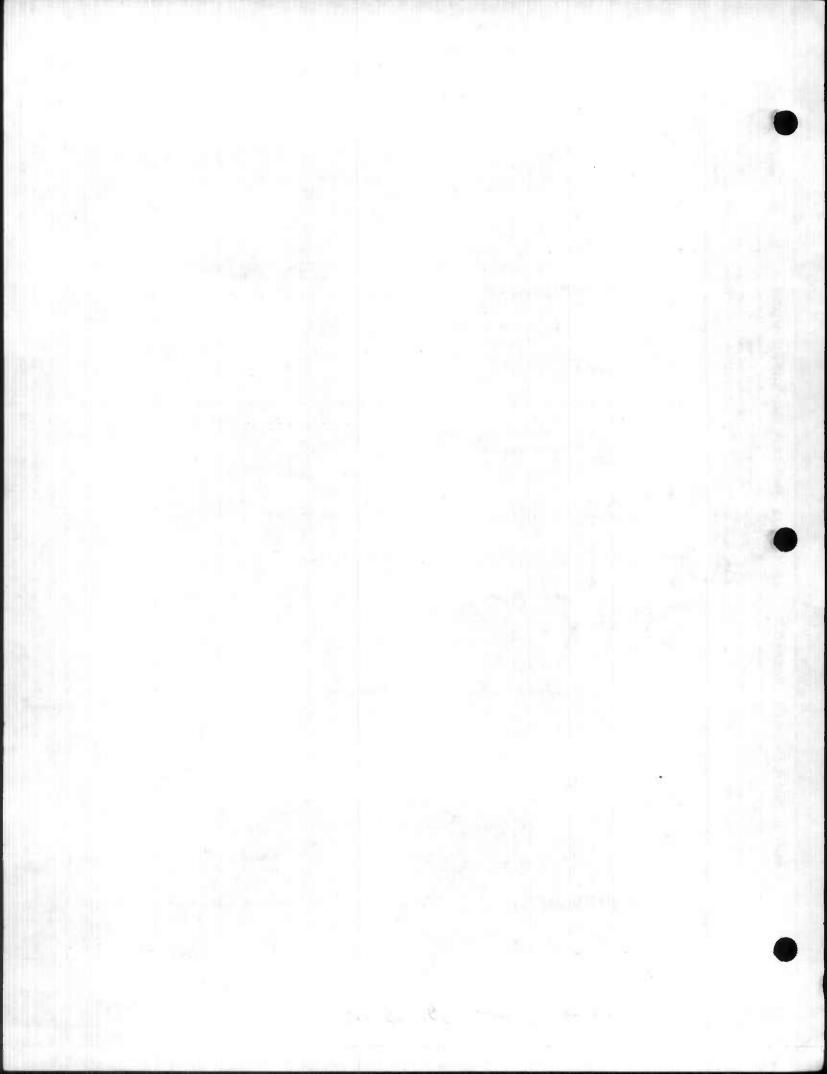
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 3. Tima of Death 2. Date of Death **Physician** Month 99 Thomas Lula Mae 01, 11:10am Aug. /Medical 4a Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 3221 Shannon Drive Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 F Yrs. NC Director 212-22-8497 84 Usual Residence of Decedent r 28e-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits MD NA XIXYas 2 □ No Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò than "natural", or harm 23s or the Medical Examiner must be. 3221 Shannon Drive 21213 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, Whita, atc. filed wilthin 72 hours after Never Married 2 Married 1 Yes ANO altimore, Maryland 21215-0020 1 ☐ Yes 2 1 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiens. Elementary/Secondary (0-12) College (1-4or 5+) 10th Grade NA Housekeeping Wesley N.H. permit. Pages 1 and 2 should be file Department of Health and Mantal Hy Important: If Nem 27 is marked oth any fillury or other traumatic event otios. 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be 2 Willie Thomas Della Ingram 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret T. King 3706 Pinkney Road Baltimore, Maryland 21215 20b. Place of Disposition (Name of 20a. Method of Disposition Dete 20c. Location - City or Town, State cemetery, crematory or other place) XIX Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Voshell Mem. Gardens 08-05-99 Dundalk, MD re of Funeral Service License 22. Name and Address of Facility WM.C. March FH 1101 E. North Avenue 1101 E. North Avenue Baltimore, MD 21202 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medi\_al Immediate Cause (Final Myocardial diseasa or condition resulting in death) Examiner Due to (or as a consequence of) Examiner law requires that the death certificets be executed physicien and a the burial-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 68760 Physician/Medical Due to (or as a consequence of) 8 for use es Box P.O. 1 signed by the e Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown Jementia, Division of Vitai Records. þ 24b. Were autopsy lindings available prior to s need should Completed 24a. Was an autopsy completion of cause of deeth? page 2 : 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No despital or Attending Physicien: Ti 4 hours efter death. \*unerel Director: After this certificat ely filled in by the funeral director, pr 8 25. Was case referred to medical axaminer? 26. Place of Deeth (Check only one) Other: 4 □ Nursing Home 5 K Residence 6 □ Other (Specify) 1 Yes 2No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Netural 1 Yes 2 No 2 Accident 6 Could not be determined 28e. Place of tnjury - At home, farm, street, lactory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number. City or Town, Stete) 4 Homicide To the Hospital or within 24 hours eff To the Funeral Dis completely filled in 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) August D6053 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bayview Circle Hopkins More 31. Date liled (Month, Day, Year) 32. Registrar's Signature State AUG 04 1999 Registrar

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#### Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Tima of Death **Physician** Tongue Vivian July 23, 1999 3:25 p.m. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner NA Sinai Hospital of Baltimore Baltimore 8. Dete of Birth (Month, Day, Year) 05-09-23 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** Months Days Hours 212-20-0202 1 M 2 X F 76 Director Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. inside City Limits MD NA Baltimore 1 Yes 2 No Director 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 503 Robert Street 21217 USA Funeral 12. Wes Decedenf Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 Never Merried 2 ☐ Merried 1 Yes 2 No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Domino Sugar Co. Laborer 12th Grade 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Fairfax Unknown Carrie 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1117 Winchester Street Baltimore, MD. 21217 Williams Augusta 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Steta 1 ♥ Burial 2 Cremetion 3 Removel from State Voshell Mem. Gardens 08-05-99 Dundalk, MD 4 Donetion 5 Other (Specify) 22. Name and Address of Facility Baltimore, Maryland 21202 21. Signature of Funerel Service Licensee WM.C.March FH 1101 E. North Avenue al ncia lan 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete nterval Betw Interval Between Onset and Deeth **Physician** /Medical Immediete Cause (Final Lactic Acidosis diseese or condition resulting in death) Examiner Due to (or as a consequence of): Examiner Hepatic Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or es e consequence of) Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 | Yea 2 | No 3 | Probably 4 | Unknown Congestive Heart Failure þ 24b. Were autopsy lindings eveilable prior to completion of cause of death? 24e. Wes an eutopsy performed? Completed 1 ☐ Yes 2 No 1 Yes 25. Was case relerred to medical axeminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Dete of tnjury (Month, Day Year) 27. Manner of Death Certification: 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigetion 1 Yes 2 No 2 Accident 6 Could not be 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. edicai

the death certificate be axec physician Box 68760 0 Records, Division of Vital

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980 0 signed a certificate has funeral director, this After i or Attending after death. Director: Aft filled in by Hospital 24 hours To the Within 2

> State Registrar

31. Date filed (Month, Day, Year)

(Check only one)

29b. Signature and little of conflict

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

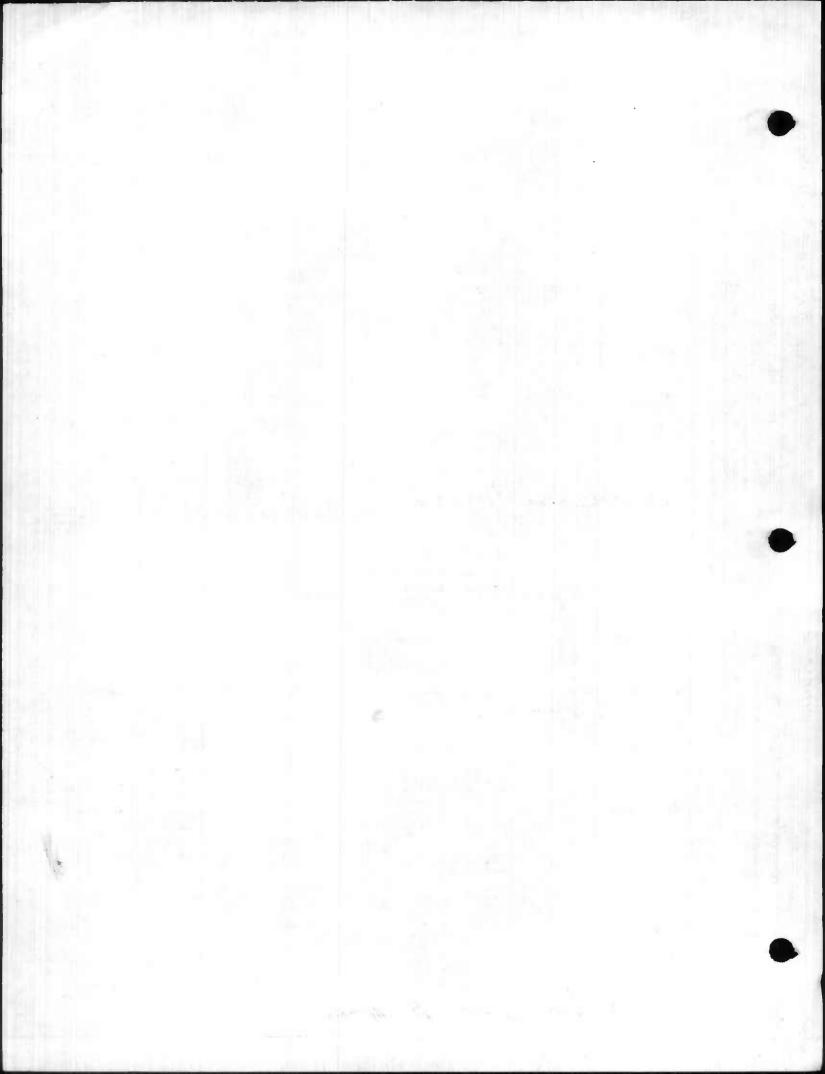
Scott Reeder, MD, PhD, 2401 W. Belvedere Ave, Baltimore, MD 21215-5271

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

P13217

29c. License number

29d. Date signed (Month, Dey, Year) July 27, 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Nadine 30 1999 July 11:10pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Baltimore Towson If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 224-24-618 Director VIRGINIA Feb. 6. Usual Residence of Decedent 10a. Stata 10b. County 10c. City. Town or Location ahow 10d. Inside City Limits Himore 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 Yes 2 V If Yes, Give Year or Dates: 2 No 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) nome 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Peges 1 and 2 should be fill Department of Health and Mental H Important: if flem 27 is marked oth any Injury or other treumatic even and all should be an extended on any Injury or other treumatic even and a 8 Peges 1 and 2 should be nent of Health end Mentel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Himore MORRIS amples 20b. Place of Disposition (Name of cemetery, crematory or other place) Aug 2 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Valley Mem. Gans 22. Name and Address of Facility & 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Eitheral Service Licen Vaus Funeral Chaper Harford 21234 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical my o cardial 48hrs Examiner Examiner disease COLONKU eaus arteru physician and s the burlet-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Cardio Vascular Atherosdero hic Physician/Medical Due to (or as a consequence of): is signed by the sid be detached for Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part It. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No þ Completed 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 M No 1 ☐ Yes 2 ☐ No certificata To the Hospital or Attending Physician: Within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p. 8 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Naturat 1 ☐ Yes 2 ☐ No 2 Accident 8 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of fnjury - At home, tarm, street, factory, office building, etc. (Specify) 4 Homicide

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Box 68760,

P.O.

Records,

Division of Vital

amres

State Registrar 29a. Certifier (Check only one)

29b. Signature and title of certifier

Huaibin Li,

31. Date filed (Month, Day, Year)

recibin Li

mo.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ste 203, 52. Registrar's Signature

6565 N. Charles St.

10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

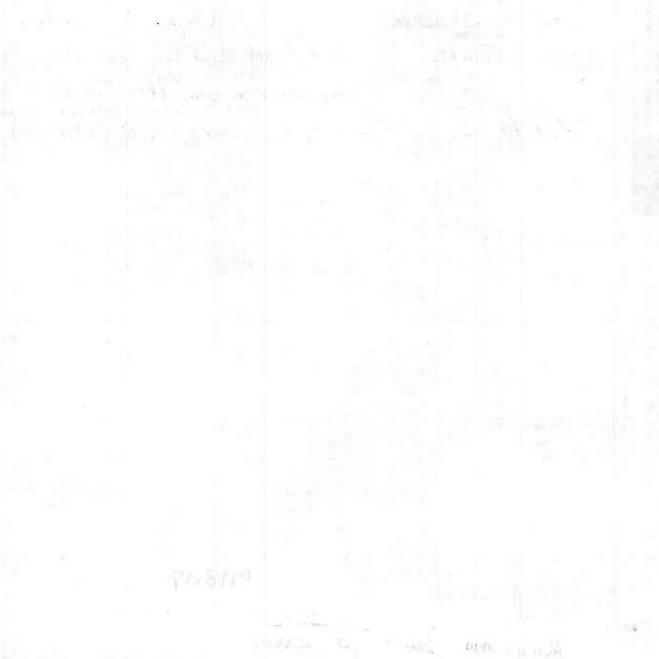
P11827

Baltimore,

29d. Date signed (Month, Day, Year)

31

MD 21204



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

**Physician** /Medicai **Examiner**  1. Decedant's Neme (First, Middla, Last)

Reg. No 2. Date of Deeth

3. Time of Deeth

3:05 PM

10d. Inside City Limits

CARE

7 Jays

1 Yes XXVo

**Funeral** 

Director

the Marylend death

Direct

Funeral

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Completed

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77 is marked other than "natural", or items 23a or 28a-f ahow traumetic event, the Mexical Examination in the high field at hours efter d 2 should be filed withln 72 th and Mentel Hygiene. 7 is merked other than "na permit. Peges 1 end 2 sh Department of Heelth and Important: If item 27 is m any injury or other traum

Baltimore, Maryland 21215-0020

Box 68760.

P.O.

Division of Vital Records.

**Physician** /Medical Examiner

Examiner

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Completed

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buriel-trensi and physician 8 thet 80 050 the 6 þ Deen page 2 has The certificate 2 this funeral Medical Certification: After

ne Hospital or Attending P n 24 hours efter death. ne Funeral Director: After t pletely To the F Within 2 To the F complet

Month Dev MARGARET H. VANDEGRIFT AUGUST 1,1999 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death HOLLY HILL MANOR NURSING HOME TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthdey) Birthpiece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Deys Hours 1 M XXX F 244-10-6630 Yrs 88 08-24-1910 DELAWARE Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location MD. BALTIMORE TOWSON 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 531 STEVENSON LANE 21286 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 14. Reca - American Indien, Bleck, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status Yes XX No 1 Never Married 2 Married 1 ☐ Yes XXNo Specify: Specify: WHITE X3 Widowed 4 Divorced Year or Detes: 16a. Decedent's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Collaga (1-4or 5+) REGISTERED NURSE HEALTH 2 YEARS 17. Fathar's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) JOHN M. HANSON MAUDE ROWE 19e. Informent's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zlp Code) JOHN A.BALDWIN (NEPHEW) 2032 FERRY FARMS RD., ANNAPOLAS, MD., 21402 20b. Plece of Disposition (Neme of cemetery, cremetary or other plece) 20e. Mathod of Disposition 20c. Location - City or Town, Stete Dete 1 ☐ Buriel **XX** remetion 3 ☐ Removel from State GREEN MOUNT CREMATORY 8-3 BALTO., MD., 21202 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licansee HENRY W. JENKINS AND SONS COMPANY NY-X ult 4905 YORK ROAD, BALTIMORE, MARYLAND, 21212 .0 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiec or respiretory errest, shock, or haert failure. List only one cause on each line. Immedieta Causa (Final disease or condition resulting in daeth) presmonia Dua to (or as a consequence of): Sequentielly list conditions, if any, laading to immediata cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or es e consequança of) Due to (or es e consequença of):

Pert II. Other significant conditione contributing to death but not resulting in the underlying cause given in Pert I.

Osteoporosis

Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work?

28e. Place of Injury - At homa, ferm, street, factory, office building, atc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

28d. Describe how Injury occurred

Other Nursing Home 5 Residence 6 Other (Specify)

24a. Was en eutopsy performed?

1 Yes XX No

Certifier (Check only one)

XX: Certifying Physician: To the best of my knowledga, death occurred et the tima, deta and plece, and dua to tha causa(s) and mannar as steted.

2 Medical Examinar: On the basis of exemination end/or invastigation, in my opinion, deeth occurred et the time, date end pleca, and due to tha causa(s) end menner stated. 29a. Certifier 29c. License number

29b. Signeture end title of certifier

5 Panding

investigation

6 Could not be determined

1 Yes 2 No

26. Placa of Deeth (Check only one)

29d. Dete signed (Month, Dey, Year)

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 donknown

24b. Wara eutopsy findings evalleble prior to completion of cause of daeth?

1 ☐ Yas 2 ☐ No

AUGUST 3,1999

30. Nema and address of parson who completed causa of daath (Itam 23a) (Type, Print)

THEODORE C. HOUK, M.D., 7825 YORK ROAD, TOWSON, MARYLAND, 21204 31. Dete filed (Month, Dey, Yaar)

State Registrar

AUG 0 4 1999

25. Was case referred to medical exeminer?

1 Yes XXNo

27. Mannar of Deeth

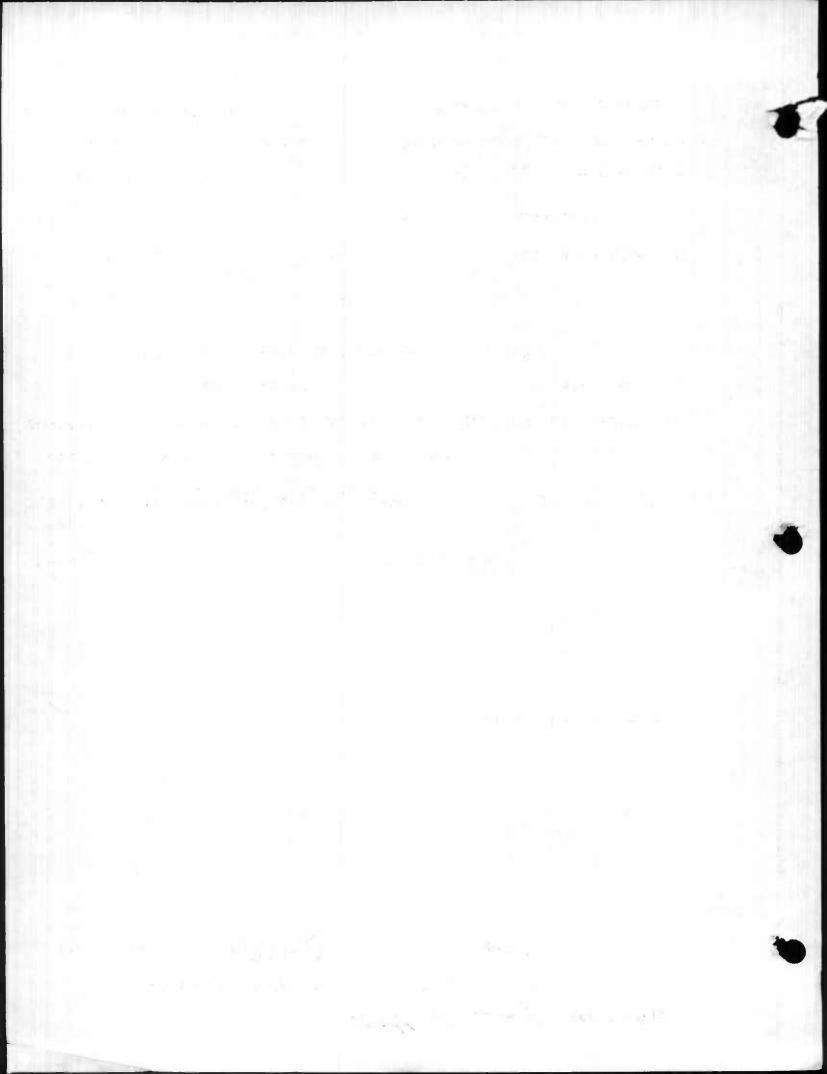
Vaturel

3 Suicide

2 Accident

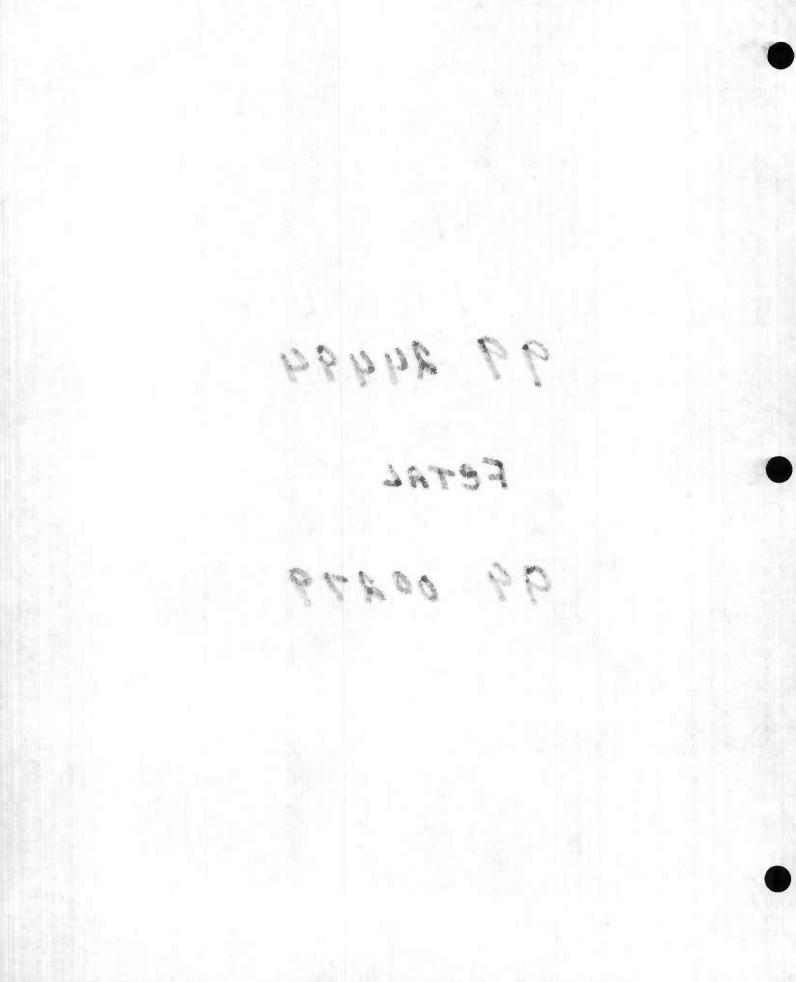
4 ☐ Homicide





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CERTIFICATE # 922\_34494
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CERTIFICATE M
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### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Edith WISE July 30, 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Johns Hopkins Bayuiew Medical (enter Baltimore 5. Social Security Number ff Under 1 Yaar | If Under 24 Hrs. | Birthplaca (Steta or Foraign Country) 8. Data of Birth (Month, Day, Year) 6. Sex 7. Aga (In yrs. last birthday) Days 1 M 25F 96 212-32-2737 SOUTH CAROLINA 8-29-03 Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1734 E. PRESTON ST U.S.A. 21213 14. Race - American Indian, Black, Whita, atc. 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) Specify: BLACK 1 ☐ Nevar Married 2 Married 1 ☐ Yas 2 ☐ XQc 1 Yas 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working tifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) UNKNOWN SELF EMPLOYED DOMESTIC 17. Fathar's Nema (First, Middla, Last) 18. Mothar's Neme (First, Middle, Maiden Surname) UNKNOWN UNKNOWN 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) ST. STEVENSON CT A1, BALTO. MD JAMES SMITH (SON) 21216 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-4-99 BALTIMORE, MD metro crematory 22. Nama and Addrass of Facility HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTO. MD 21207 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata fntarval Between Onset and Death Immediete Causa (Final disaasa or condition rasulting in deeth) Dua to (or as a consequence of) Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disease or injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part t. 23b. Did tobacco usa contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown Anemia Stage 111-1V Socral decubitus 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? completion of cause of death? 2 L 1 ☐ Yes 2 ☐ No 1 Yes 26. Placa of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Date of tnjury (Month, Day Year) 28c. Injury at Work? 28b. Tima of 28d. Describe how injury occurred 1 Naturel 5 Pending invastigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide

Examiner physician and s the burial-transit that the death certificate be assecuted Box 68760. Physician/Medical P.O. p Records. Be Completed certificate Division of Vitai or Attending Physician: Certification: To this After death. To the Hospital or Attendition 24 hours after death.
To the Funeral Director: A completely filled in by the fu

**Physician** 

/Medical

Examiner

Funeral

**Director** 

or 25a-f show

Herrie 23a

"natural", or

permit. Pages 1 and 2 should be film.
Department of Health and Merial Hyp.
Important: If them 27 is marked Hyp.
any injury or other.

Physician /Medical

Examiner

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Funeral

Completed

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the Maryland

hours after

Baltimore, Maryland 21215-0020

25. Was casa rafarred to medical 27. Mannar of Death 6 Could not be datarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicids 29a. Cartifiar 1 💆 Certifying Phyafcfan: To tha best of my knowledga, deeth occurred et the tima, data and place, and dua to tha cause(s) and mannar as stated (Check only one) 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signatura and titla of certifia

29c. License number 98021

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

Johns Hopkins Bayview Medical Cernter, Baltimore, MD 21224

29d. Data signed (Month, Day, Year)

State Registrar

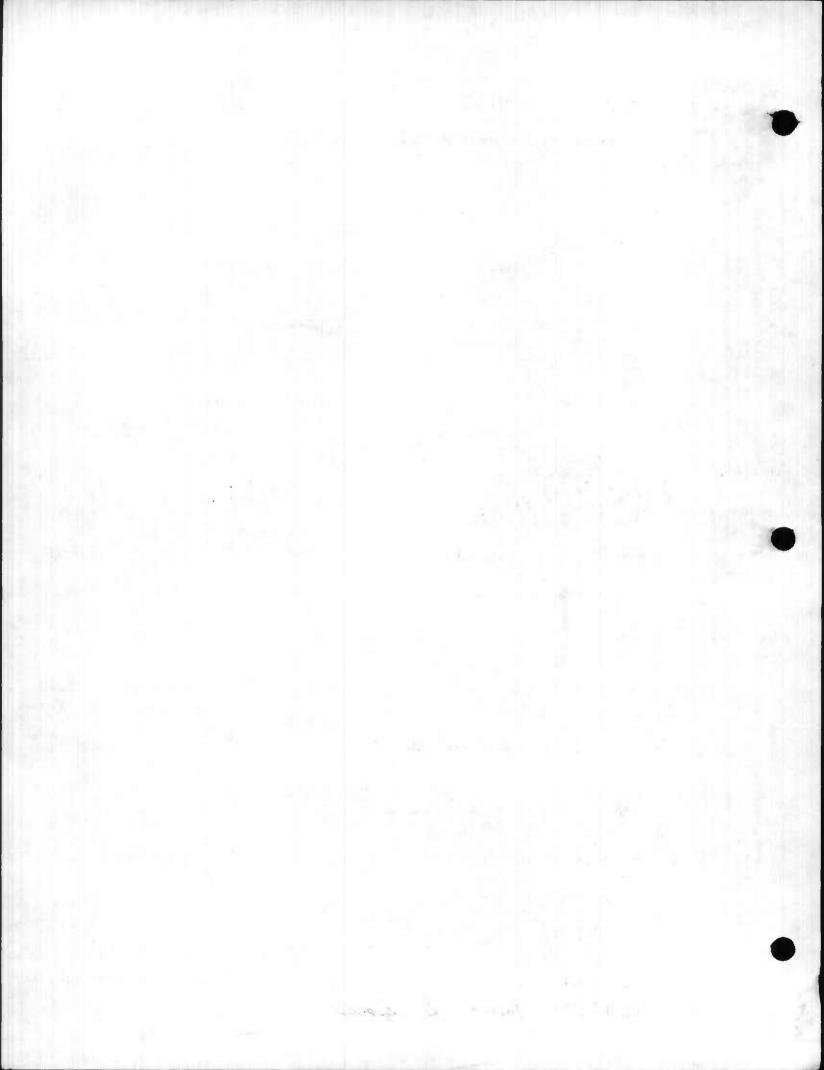
Medical

31. Data filed (Month, Day, Year) AUG 0 4 1999

BROWNER

32. Registrer's Signeture

**DHMH 16 Ray 6/95** 



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 4b. City, Town, or Location of Deeth 16:42 Pm BAlthrone 5. Social Security Number

212-44-8963
Usual Residence of Decedent If Under 1 Year 7. Age (In yrg. lest birthday)
Yrs. If Under 24 Hrs. hplece (State or Foreign Months Days 100 M 2□ F 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No Maryland 10e. Street and Numbe 10g. Citizen of What Country 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 M No
If Yes, Give
Year or Dates: 13. Was Decedent Race - American Indian, Black, White, etc. 11. Meritel Status 1 Never Married 2 ☐ Married 1 Yes 2 No Specify: Afro-American 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Sabl ed 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and I) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) 21. Signature of Funeral Service License Joseph L. Russ tu 2222 W. North Ave. er Approximate Interval Between Onset and Deeth Immediate Cause (Final disease or condition resulting In deeth) Sequentielly list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Acidosis Due to (or as a consequence of) Duermon. a Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveileble prior to completion of cause of death? 24a. Wes an autopsy performed? COPD 1 ☐ Yes 2K No 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Annpatient 2 ER/Outpetient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending Investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(s) and manner stated. 29e. Certifier

Examiner Ö Records, Division of Vital

**Physician** 

/Medical Examiner

Funeral

Director

28a-f show

ò items 23a

"natural", or

permit. Pages 1 and 2 should be filed within Department of Health and Mentel Hygiene, important: If item 27 is merked other than any injury or other traumatic event, it a Magnes.

Physiclan

Physician/Medical Examiner

Certification: To

(Check only one)

29b. Signature and title of certified

AUG 04 1999

Baltimore, Maryland

by

Completed

To the Hospital or Attending Physicien: within 24 hours efter death.

To the Funeral Director: After this certifice completely

Registrar

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

RES-001

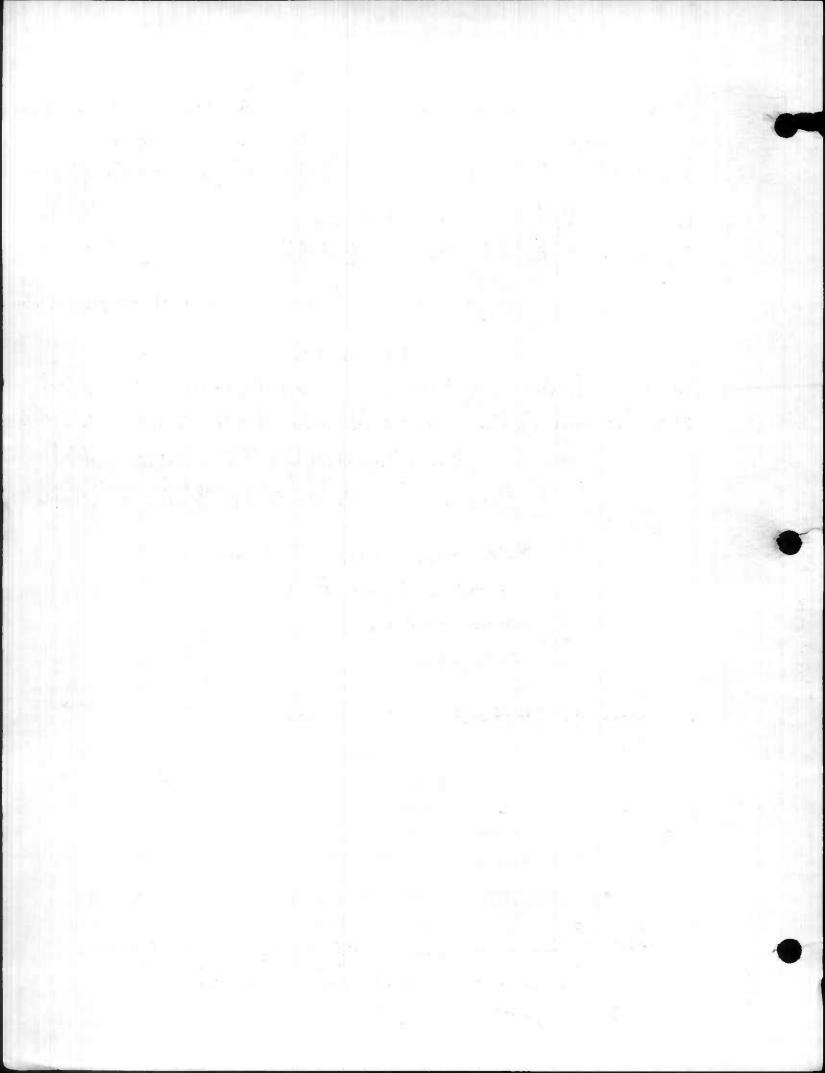
29c. License number

29d. Date signed (Month, Day, Year)

W. II. un F.
31. Dete filed (Month, Dey, Year)

2401 Usit Belvedere Avenue

Kulka MD Sha Sinai Hoyibl, BAltmore, MD 21215



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

		State of Maryland / Department of Health and Certificate of Death	d Mental H	ygiene Reg. No. 99	24497														
Physici /Medic		1. Decedant's Nama (First, Middla, Last) ROSALIE A. Windson	2. Data of D Month		3. Tima of Death														
Examin Funeral Director		4a. Facility Nama (If not institution, give street and number)  4b. City, Town,  **Resultant Multicare 700 W. 40th St. Balt  5. Social Security Number  6. Sax 7. Aga (In yrs. last birthday) Hi Undar 1 Year If Undar 24 H  4b. City, Town,  Balt  5. Social Security Number  6. Sax 7. Aga (In yrs. last birthday) Months Days Hours N		N/A irth year) 9.															
land we		Usual Rasidence of Dacedant  10a. Stata 10b. County 10c. City, Town or Location			10d. Insida City Limits														
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ith the M or 28a-f	Director	10e. Street and Number 10f. Zip Coda		10g. Citizan of Wha	t Country?														
ath w	rai	141 EAST WEST ST. 21230		USA															
5-0020 72 hours efter death with the Meryland natural', or frems 23e or 28e-f show dical Examiner must be notified at	by Funeral	11. Marital Status  1 Navar Marriad 2 Married  3 Widowed 4 Divorced  12. Was Decedant Evar in U,S. Armed Forcas?  1 Navar Marriad 2 Married  1 Navar Marriad 2 Married  1 Navar Marriad 2 Married  1 Navar Marriad 2 Married  1 Navar Marriad 2 Married  1 Navar Marriad 2 Married  1 Navar Marriad 2 Marriad  1 Navar Marriad	(Specify Yas or N larto Rican, atc.)	Specify:	Amarican Indian, Vhita, atc. WHITE														
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	S	1 2 Y R S MANAGER - TELEPHONE 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Last)	NE CO. TELEPHONE CO.  ner's Name (First, Middle, Malden Sumame)																
E daby	To Be			HWERMAN															
re, Maryla s 1 end 2 should f Health end Men tem 27 is merke other traumatic		19a. Informant's Name/Ralationship (Type, Print)  19b. Mailing Addrass (Straat and Number or			ta, Zip Coda)														
		ROGER M. WINDSOR (SON) 4023 DEEPWOOD RD																	
S 85 5 8		20a. Mathod of Disposition  1 Burial 2 Cramation 3 Ramoval from Stata 4 Donation 5 Othar (Specify)  20b. Place of Disposition (Nama of cematary, cramatory or othar placa)  GREEN MOUNT CREMATO	Data RY07/28	20c. Location - City															
Balting permit. Pa Departmen Important: any injury once.		21. Signature of Funaral Sarvice Licensaa  22. Nama and Address of Facility  HENRY W. JENK 4905 YORK RD.	INS & S	ONS CO.	12.														
		23a. Pert1. Entar the diseesa, or complications that caused tha daath. Do not antar tha mode of dying, such as card shock, or haart failura. List only one cause on each line.	fiac or raspiratory	arrast,	Approximata Interval Between														
Physician /Medical Examiner		Immedieta Causa (Final disaasa or condition rasulting in daeth)  a. Cangalwe heart faulure	હ		3 days														
	edic	edicai	Sequantially list conditions, if any, laading to immadiate cause. Entar Undaryling Cause (Disaasa or injury that initiated evants rasulting in daath) Last  Dua to (or as a consequence of):  Dua to (or as a consequence of):  C			Jage													
	sicla	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did	tobacco use contrib	ute to the cause of death?														
	by Physiclan/M	att in the state of the state o			Probably 4 Unknown														
Na W										Completed								s an autopsy ormed?	b. Wara autopsy findings available prior to complation of causa of death?
- F # 6 A			10	Yas 2 No	1 ☐ Yas 2 ☐ No														
Of Vital Re Physician: The intelestral director, page	To Be	Hospital: Other:	eath (Check only																
0 5 5 8		27. Mennar of Death  1 Natural 5 Pending (Month, Day Year)  28b. Tima of Injury 28b. Tima of Injury Work?  2 Accident invastigation  28c. Injury at Work?  1 Yas 2 No		5 Residence 6 Other (Specify)  Dascribe how injury occurred															
DIVISIO  Ital or Attendi irs after death. al Director: A led in by the fu	Certifi	3 Suicida 6 Could not be datarmined 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify)		(Straat and Number of wn, Stata)	Rural Routa Number,														
To the Hospital is within 24 hours a To the Funeral Completely filled	ledical	29a. Cartifiar (Check only one)  1 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and pla companies. On the basis of axamination and/or invastigation, in my opinion, daath occurred at the tima, data and pla companies.	ce, and dua to tha curred et tha tima,	causa(s) and manner data and plece, and	r as etated. dua to the cause(s)														
o T with	Σ	29b. Signatura and title of cartifliar  29c. Licansa number		29d. Data signed (M															
T 1X		m. I thele man freger or 8 0/3657		July 27	11999														
W6		30. Nema and address of person who complated causa of deeth (Itam 23a) (Type, Print)  7. DABELLE MAGREGOR, KESWICK, 700 W. 40 % STREET  31. Data filad (Month, Day, Year)  32. Registrar's Signature	BALT																
Stat Registra	_	AUG 0 4 1999 Server B. Sparks																	

DHMH 16 Rev 6/95

Samuel Cill Ha Sun

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔾 🔾 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Deta of Death 3. Time of Death Month **Physician** Elizabeth Winter Mary 07 29 1999 12:15pm /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not Institution, giva street and number) 4c. County of Deeth Examiner Stella Maris Baltimore Towson If Under 1 Year 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (Stata or Foraign Country) **Funeral** Days Months Hours 1□ M 20 F 216-05-4813 80 Yrs 2-28-1919 Director Baltimore Usual Rasidence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location r than "natural", or itema 23a or 28a-i ahow the Medical Examiner must be notified at 1 Yes 2 □ No Directo Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4318 LaSalle Avenue 21206 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 14. Raca - American Indian, Black, Whita, atc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Status efter 1 Yes 2 No if Yes, Give 1 Nevar Married 2 Married Specify: White 1 Yes 2 No Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Businass/Industry Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) 2 12 Home Maker Own Home other t 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) permit. Pages 1 and 2 should be fill Department of Health and Mentel Hy Important: If Item 27 Ia marked oth any Injury or other traumatic event Be Edward Eichelman Christine Shruefer 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) William J. Winter Sr.-Husband 4318 La Salle Ave. Baltimore, Md. 21206 20b. Place of Disposition (Name of cemetary, crematory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition 1 Burial 2 Cramation 3 Removal from State Parkwood Cemetery 8-2-1999 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funaral Sarvice Licenses 22. Nama and Addrass of Facility Leonard J. Ruck Funeral Home 5305 Harford Rd. Baltimore, Md. 21214 Jary Tiovanne Approximate Interval Batween Onset and Death 23a. Part1. Enter the disaesa, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or haart failure. List only one cause on each line. **Physician** 1/168552 EKYONIC 4547 /Medical tmmediata Causa (Final diseasa or condition rasulting in death) Examiner Due to (or as a consequence of) Examiner and Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physiclan Physician/Medical tha Due to (or as a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 94 Alexen J. 15301 2 1 Yea 2 No 3 Probably Driknown þ 24b. Wara eutopsy findings evailable prior to Completed 24a. Was en autopsy performed? peed completion of cause of death? page 2 1 ☐ Yes 2 ☐ No 25 No 25. Was case rafarred to medical examinar? Be 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yas 2 36 1 Inpetient 2 ER/Outpatient 3 DOA this 28a. Date of tnjury (Month, Day Year) 27. Mannar of Death 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred To the Hospital or Attanding Pi within 24 hours after death. To the Funeral Director: After th completely filled in by the funera After 5 Pending invastigation Natural 1 Yas 2 No 2 Accidant 6 Could not be determined 3 Suicida 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida edical Carrying Physician: To the best of my knowledge, death occurred at the time, data and place, and dua to the cause(s) and manner as stated. 29a. Certifier Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data end place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature 29c. License number 9.69.95.

State Registrar 31. Date filed (Month, Day, Year)

AUG 04

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Box 68760.

of Vital Records, P.O.

Division

ORIGINAL

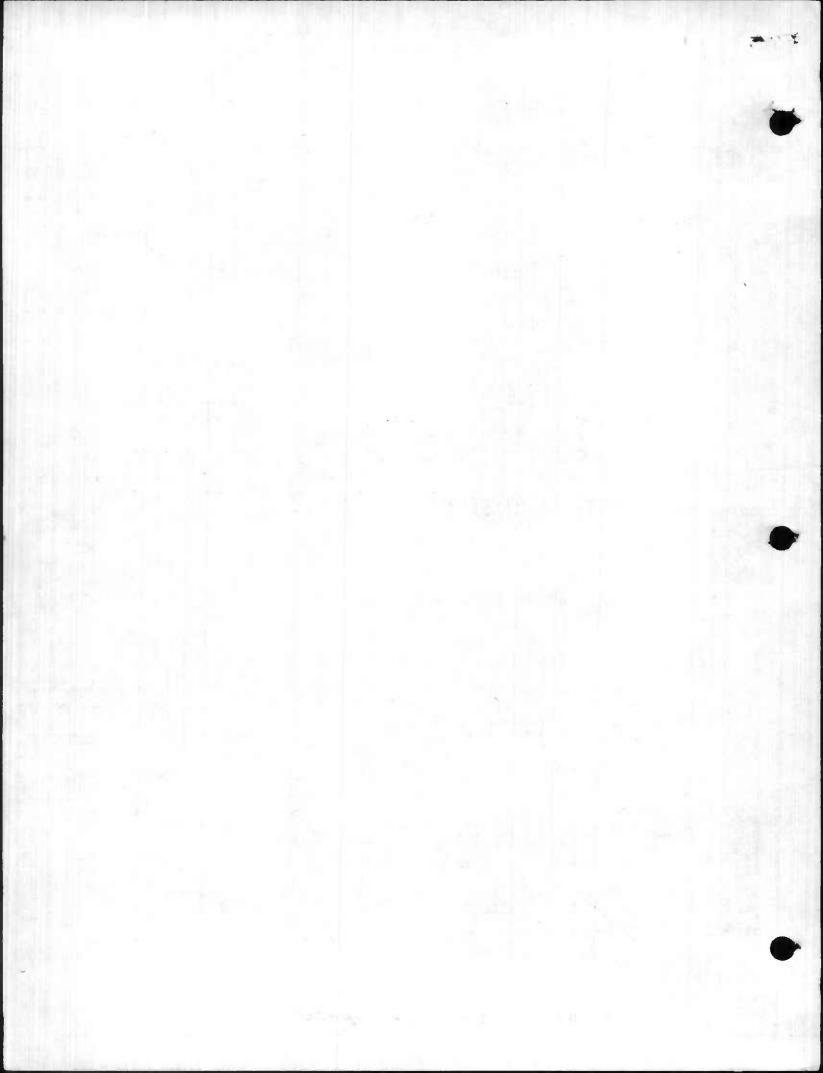
21093

Timonium, Md.

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

Dr. Eddie Nakhuda 2300 Dulaney Valley Rd.

32. Registrar's Signature



## Please Type or Print In Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Time of Death Day ALEXANDER 4b. City, Town, or Location of Death 1999 19, 9:10 AM THERESA 4a Facility Nama (If not institution, giva street and number) 4c. County of Death ANNE ARUNDEL MEDICAL CENTER Annapolis
If Under 1 Year | If Under 24 Hrs. Anne Arundel 8. Data of Birth (Month, Day, Year) . Age (fn yrs. last birthday) Birthpleca (Stata or Foraign Country) 1□ M 25 F Months Days Hours Min Yrs. 577-20-0300 Usual Rasidenca of Decedant October 16,1921 Washington, D.C. 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 ☐ No Queen Anne Stevensville 10f. Zip Code 10g. Citizan of What Country? U.S.A. 21666 107 Monoponsan Drive 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Rece - American Indian. Bleck, White, etc. 1 Yes 2 No If Yas, Giva Yeer or Datas: 1 Never Married 2 Married 1 ☐ Yas 2 ☐ No Specify. 3 ₩Widowed 4 Divorced White 16a. Decedant's Usual Occupetion (Give kind of work dona during most of working life. DO NOT usa retired) 15. Decedant's Education (Specify only highest grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant U.S. Gov't. 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middla, Maidan Surnama) Annie Morris Hayden Graves 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

107 Manapansan Drive, Stevensville, MD 21666

7/24/99

4111 Pennsylvania Ave., Suitland, MD 20746

permit. Peges 1 end 2 should be filed within 72 hours efter death with the Merylen Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examples must be notified at once. Funeral Baltimore, Maryland 21215-0020 p Completed Be

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

with the Meryland

ANN

10a. Stata

Maryland

11. Marital Status

12

Sandra Alexander

4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funaral Sarvice Licensee

1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata

20a. Mathod of Disposition

10e. Street and Number

Directo

**Physician** /Medical **Examiner** 

attending physician end for use as the buriel-trensit that the death certificete be executed page 2 certificate

Division of Vital Records, P.O. Box 68760, or Attending Physician: After this funeral s after deeth. 2 Hospital • Funeral pletely

Examiner

Physician/Medical þ Completed Be Certification: To

edical

If the disease of complications that caused the death. Do not anter the mode of dying, such as cardiac or respiretory errest, heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Docubiles ulcan Dua to (or as a consaquance of): Moregin Sequentially list conditions, if any, laading to immediata causa. Enter Underlying Cause (Disease or Injury that initiated avants rasulting in death) Last Due to (or as a consequence of): Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 12 00 2 No 3 Probably 4 Unknown Casi 24a. Was an autopsy

20b. Placa of Disposition (Nama of camatary, cramatory or other placa)

22. Nama end Addrass of Facility

Oedar Hill Cemetery

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yas 2 ☐ No 1 Yas 2 300 25. Wes casa ratarred to medical axaminar? 26. Placa of Daath (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 1 Yas 200No Inpatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. injury at Work? Natural 5 Pending 1 Yas 2 No Invastigation 2 Accident 6 Could not be datamined 281. Location (Straat and Number or Rural Routa Number, City or Town, State) 3 Suicida 28e. Pleca of Injury - At homa, farm, street, fectory, office building, atc. (Specify) 4 ☐ Homicida Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

(Check only one) 29b. Signature end title of certifie

29a. Certifiar

29c. License number 032036 29d. Date signed (Month, Day, Year)

20c. Location - City or Town, Stata

Approximata Interval Between Onsat and Death

Suitland, MD

Cedar Hill Funeral Home, Inc.

30. Name and address of person who completed cause of death (Itam 23a) (Typa, Print)

Danaho Prive Charles mo 216/9 21091. (aar 31. Data filed (Month, Day, Year) 2 2 1999

State Registrar 32 Registrer's Signatura

To the F within 2

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

	State of Maryland	Certificate of	Death	Reg. No.	99 2450	0		
1. Decedent's Nama (First, Middle, Las ELIZABETH AXX	ENFELD			Data of Death Month Day 2	1 99 15	50 Pin		
376-34-1404	ON HOSPITAL	4	FORT WASHII  If Undar 24 Hrs. Hours Min.  A		County of Death  RINCE GEORG  9. Birthplaca (Stata or Country)  SCOTLand			
Usual Rasidenca of Decedent  10a. Stata 10b. County Maryland Prince Ge		own or Location Ft. Wa	ashington		10d. Inside City			
10e. Street and Number 13117 Glasgow Way 11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced		10f. Zip Code 20744	4	10g. Citiz	zen of What Country?			
11. Marital Status  1 Nevar Married 2 Married  3 Widowed 4 Divorced	12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas:	13. Was Decedent of H If Yas, specify Cuba 1 ☐ Yas 2 ☑ No	lispanic Origin? (Specify an, Mexican, Puarto Rica Specify:		4. Race - American Indian, Black, Whita, atc. Specify: White			
15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation 1st completed) College (1-4or 5+)	6a. Decedent's Usual Occup (Giva kind of work done of life. DO NOT usa retired Salesperson	etion during most of working d)		nd of Businass/Industry			
17. Fathar's Nama (First, Middla, Last) George	Fielding		18. Mothar's Nama (Fir Annie	ma (First, Middle, Maiden Sumama) McQueen				
19a. Informant's Name/Ralationship (7)  Kevin Axenfeld/So  20a. Mathod of Disposition	on 9	9b. Mailing Addrass (Street: 9316 Kenbrook) of Disposition (Nama of tary, cramatory or other place)	e Ct., Laure	el, MD 20				
23a. Part 1. Enter the disease, or compshook, or heart failure. List only compared to condition resulting in death)	Mary Mary Mary Mary Mary Mary Mary Mary	6160 Oxon I	ss of Facility Kalas Funera Hill Rd., Ox	al Home, P xon Hill, spiratory arrest.		reen		
Sequentially list conditions, if any, leading to immadiata cause. Entar Undarfying Cause (Disease or injury that initiated events rasulting in death) Last	b. QRR Due to (or as	a consequence of):			yns			
Part II. Other elignificant conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Did tobacco use contribute to the cause of the c								
				24a. Was an autop performed?	24b. Wara autopsy fir available prior to completion of ce of death?	ause		
25. Was case referred to medical examinar?  1  Yas 2 No  27. Manger of Death    Natural 5  Pending invastigation	Cocurred							
2 Accidant invastigation 3 Suicida 6 Could not be datarmined	d Number or Rural Route Numb	ver,						
29a. Cartifier (Check only one)  29a. Cartifier (Check only one)  20a. Cartifier (Check only one)								
29b. Signatura and the of person who co	ompleted causa of death (Item 23	29c. Licansi	943/	29d. Date	19d. Data signed (Month, Day, Year)			
state 31. Data filed (Month, Day, Year)  Strar  JUL 2 3 1999	32, Registrar's Signatura	Livingson.	(P) #203'	tt. ws	of MD ZUTY	14		

DHMH 16 Rev 6/95

